HEALTH INSURANCE COVERAGE AND REFORM

HEARING

BEFORE THE

SUBCOMMITTEE ON
HEALTH AND THE ENVIRONMENT

OF THE

COMMITTEE ON
ENERGY AND COMMERCE
HOUSE OF REPRESENTATIVES

ONE HUNDRED FIRST CONGRESS

FIRST SESSION

MARCH 9, 1989

Serial No. 101-18

Printed for the use of the Committee on Energy and Commerce

U.S. GOVERNMENT PRINTING OFFICE
98-680⇒ WASHINGTON : 1989

For sale by the Superintendent of Documents, Congressional Sales Office
U.S. Government Printing Office, Washington, DC 20402

COMMITTEE ON ENERGY AND COMMERCE

JOHN D. DINGELL, Michigan, *Chairman*

JAMES H. SCHEUER, New York
HENRY A. WAXMAN, California
PHILIP R. SHARP, Indiana
JAMES J. FLORIO, New Jersey
EDWARD J. MARKEY, Massachusetts
THOMAS A. LUKEN, Ohio
DOUG WALGREN, Pennsylvania
AL SWIFT, Washington
MICKEY LELAND, Texas
CARDISS COLLINS, Illinois
MIKE SYNAR, Oklahoma
W.J. "BILLY" TAUZIN, Louisiana
RON WYDEN, Oregon
RALPH M. HALL, Texas
DENNIS E. ECKART, Ohio
BILL RICHARDSON, New Mexico
JIM SLATTERY, Kansas
GERRY SIKORSKI, Minnesota
JOHN BRYANT, Texas
JIM BATES, California
RICK BOUCHER, Virginia
JIM COOPER, Tennessee
TERRY L. BRUCE, Illinois
J. ROY ROWLAND, Georgia
THOMAS J. MANTON, New York

NORMAN F. LENT, New York
EDWARD R. MADIGAN, Illinois
CARLOS J. MOORHEAD, California
MATTHEW J. RINALDO, New Jersey
WILLIAM E. DANNEMEYER, California
BOB WHITTAKER, Kansas
THOMAS J. TAUKE, Iowa
DON RITTER, Pennsylvania
THOMAS J. BLILEY, JR., Virginia
JACK FIELDS, Texas
MICHAEL G. OXLEY, Ohio
HOWARD C. NIELSON, Utah
MICHAEL BILIRAKIS, Florida
DAN SCHAEFER, Colorado
JOE BARTON, Texas
SONNY CALLAHAN, Alabama
ALEX McMILLAN, North Carolina

WM. MICHAEL KITZMILLER, *Staff Director*
MARGARET A. DURBIN, *Minority Chief Counsel/Staff Director*

SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT

HENRY A. WAXMAN, California, *Chairman*

JAMES H. SCHEUER, New York
DOUG WALGREN, Pennsylvania
RON WYDEN, Oregon
GERRY SIKORSKI, Minnesota
JIM BATES, California
TERRY L. BRUCE, Illinois
J. ROY ROWLAND, Georgia
MICKEY LELAND, Texas
CARDISS COLLINS, Illinois
MIKE SYNAR, Oklahoma
RALPH M. HALL, Texas
BILL RICHARDSON, New Mexico
JOHN D. DINGELL, Michigan,
(Ex Officio)

EDWARD R. MADIGAN, Illinois
WILLIAM E. DANNEMEYER, California
BOB WHITTAKER, Kansas
THOMAS J. TAUKE, Iowa
THOMAS J. BLILEY, JR., Virginia
JACK FIELDS, Texas
HOWARD C. NIELSON, Utah
MICHAEL BILIRAKIS, Florida
NORMAN F. LENT, New York
(Ex Officio)

KAREN NELSON, *Staff Director*
PETER BUDETTI, *Counsel*
MARY MARGARET MCGRANE, *Minority Counsel*
HOWARD COHEN, *Minority Counsel*

CONTENTS

HEALTH INSURANCE COVERAGE AND REFORM

THURSDAY, MARCH 9, 1989

HOUSE OF REPRESENTATIVES,
COMMITTEE ON ENERGY AND COMMERCE,
SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT,
Washington, DC.

The subcommittee met, pursuant to notice, at 9:50 a.m., in room 2123, Rayburn House Office Building, Hon. Henry A. Waxman (chairman) presiding.

Mr. WAXMAN. The meeting of the subcommittee will please come to order. Today we will begin the subcommittee's efforts to overcome the many serious problems with health care coverage that so many people now must face.

This country has made a commitment to private employment-based health insurance. This has worked very well for the most part, but that system is not perfect. Many of us are already all too aware that some 37 million Americans have no health insurance. In plain and simple terms, this is a national disgrace.

After nearly 40 years in which coverage expanded remarkably through employment related insurance, Medicare and Medicaid, the number of uninsured grew by 1 million each year for the last 8 years. This is intolerable and must be reversed.

What is particularly surprising is that so many of the people without insurance are falling through cracks in our employment-based system. Two-thirds of the people in this country that have no health insurance are, in fact, workers and their families. When uninsured people get sick and manage to get health care, somebody ends up paying the bill.

Public hospitals and public programs are drained. Private hospitals and doctors must charge people with good insurance more to make up for what they don't collect from people with inadequate insurance. That runs up the health care bills for companies that provide health benefits for their own workers. This situation is not fair; it is not fair to taxpayers, not fair to business' that are good citizens and provide health benefits.

What we need to do is spread the cost of covering workers across all employers and spread the risk of illness fairly among insurance companies. If we are going to have an employment-based system of health care coverage in this country, we have to make sure that all employers pay their fair share. If we are going to rely on private health insurance companies, we have to make sure they charge fair rates and provide adequate coverage when people need it.

Once we decide what is fair to expect of employers, then we can define and provide for public programs to cover everyone who is

left without insurance. It's one thing to ask the public to pay for covering those who are outside of the employment-based system, but it's another thing to ask the public to bear the burden for business' that don't provide health insurance to their workers when they could.

In addition to all the problems facing people with no insurance, we are hearing more often that there are problems for people seeking private insurance protection. Individuals and small business' that want to cover their workers can't find a fair price.

There are loopholes in what is actually covered, such as the exclusion of so-called preexisting conditions. When the policy has been in force long enough to start paying for the care that people need and a costly illness occurs, the insurance company can raise the price to prohibitive levels. Then, people who thought they were protected by insurance find themselves out on the street looking for another insurance company and the cycle starts all over again.

So, we have inadequate coverage for those who we thought would be covered by private insurance and others without health care coverage at all. These are problems that are not new but they are getting worse. And over the last year or so, we have seen a new wave of concern, not just here in the Congress, but among business' and health care providers and community leaders. A common recognition of the problem can lead to the consensus we need as a society to act.

Last year we joined with Senator Kennedy introducing the "Minimum Health Benefits for All Workers Act." That bill would have required all employers to provide insurance for their workers. I always viewed that legislation as one piece of our efforts to assure decent health care for all Americans.

We learned a lot from our hearings on that proposal, but the debate over that bill focused only on its potential impact on employers and, to some degree, we lost sight of the bigger picture.

Today we begin anew our exploration of these health insurance issues. It is our expectation that these hearings will help us design legislation that can achieve the necessary consensus and can be enacted during this Congress. These problems are too serious and affect too many people's lives to wait longer for a solution.

Before I call on our first panel, I want to see if any other members of the committee have opening statements. Mr. Scheuer, do you have an opening comment?

Mr. SCHEUER. Thank you, Mr. Chairman. Mr. Chairman, I congratulate you on convening today's hearings on the health insurance coverage and health insurance reform. Nothing in our country needs to be reformed more than the way we organize health care in this country and the way we pay for health care in this country.

If we stay the current course, Mr. Chairman, we are going to end up with a two-tiered health system. Those who can afford to pay the price will receive the most technologically advanced medical care available anywhere in the world, while average families will be struggling to obtain basic health care services that they need, and this at a horrendous cost.

The 37 million people who lack any public or private health insurance now receive their health care in the most expensive possi-

ble way, through the emergency rooms in our hospitals. That care is not systematic because those facilities are organized for emergency care, and are not really equipped to render the kind of primary care the noninsured often need.

Now this isn't what the American people want. They believe in equal access to equal care, and at a reasonable cost with health care delivered in an efficient, logical, cost-effective way.

Last year, Mr. Chairman, I chaired a series of nine hearings on the future of health care in America for the Joint Economic Committee. Several of your witnesses who are here this morning, a former colleague Paul Rogers and Uwe Reinhardt from Princeton and Mr. Schramm, testified at our hearing. They testified that we must reform our system to provide more and better medical care for the awesome sums that we as a Nation already pay for health care services.

Dr. Reinhardt as I recall, testified that we could squeeze 20 to 25 percent of the costs out of our health care system. Am I quoting your more or less correctly, Dr. Reinhardt? Joe Califano testified along the same lines, too, saying that we could save in excess of $100 billion if we rationalized our health care system.

Dr. Reinhardt and Joe Califano also testified that 25 to 30 percent of all health care provided—including treatments, operations, drugs and tests—is either unnecessary or actually harmful to the patient. They said we ought to learn what works and what doesn't work out of compassion for patients if not for the taxpayers.

We pay 11 or 12 percent of our GNP for health care, which is wasteful compared to the other 22 countries of the OECD who on average pay about 8 percent of the GNP's for health care. Yet, those countries provide as good or better health care than we do. We are about 20th in the world in infant mortality and we rank in the bottom third of the industrialized countries in life expectancy at birth.

That's not a record that we can be proud of, particularly in view of the fact that we pay 50 percent more than the average of the industrialized countries in the world. We have to think long and hard about how is it that we pay so much more and receive so much less. How is it that our industrial competitors around the world evidently receive equal or better care and in the process pay much less, even though they provide virtually universal access to their health care systems.

The answer seems to be that they have National Health Insurance systems that are designed by government and monitored by government, while we have a pluralistic system that is chaotic, that is duplicative, overlapping, and that is largely controlled by the providers.

Mr. Chairman, it is perfectly obvious that no national health care system in the world can be transferred lock, stock and barrel to our country. Each country is unique, especially our own. But certainly, there are a lot of lessons to be learned out there. If we are to make comprehensive high quality health care available to every American in the future, we have to learn those lessons and we have to devise a new health insurance program that will squeeze out the large amounts of waste that are endemic to our current system and allow us to use our health care dollars far more wisely.

Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you, Mr. Scheuer. Dr. Rowland, do you have an opening comment?

Mr. ROWLAND. Thank you, Mr. Chairman. May I commend you on this hearing. I think this is a most important subject that is being addressed here today. No doubt, and I hear this often in town hall meetings that I have, concern expressed about access to care, about quality of care particularly from older people who are very concerned that they will not be able to pay for the care and will not have access to it.

This is certainly something that needs to be addressed. The 37 million Americans that we hear about that don't have health insurance, who do not qualify for Medicaid but do not have access through Medicare and that do not have insurance, I am concerned that the Congress might move in a direction of a national health service to the detriment of what I believe is a system that continues to provide the best quality of care of any system in the world.

There are many reasons for the increase in cost of care that we have, and I won't try to enumerate all of those just now. I believe that the private practice that we have, this system of private practice that we have had in this country is in large part responsible for the quality of care that we have. I think that we should focus on trying to preserve that system when we also focus on trying to be sure that those people in our society who do not have access to care get quality care.

I caution that we not do something that would jeopardize the quality of care that we have in this country, and at the same time, realizing that we have to do something to provide those people who don't have the care with that.

I look forward to hearing the testimony of those here today that have come and thank you for the opportunity to be here.

Mr. WAXMAN. Thank you very much, Dr. Rowland. Mr. Dingell.

Mr. DINGELL. Thank you, Mr. Chairman. Mr. Chairman, I commend you for having these hearings. The hearings are timely. They require us to confront again, the seemingly insoluble riddles of our Nation's health care system.

Why does the richest industrial nation on earth have the western world's highest infant mortality rate? Why does the United States have more uninsured people than all western countries put together? How can the most elaborate and expansive health care system in the world be among the most wasteful and the least inclusive? How can a nation which leads the world in research and treatment and technologies be so ill-equipped to provide long-term care; care for AIDS patients, trauma care, and basic health services to large segments of its populations?

Why in a Nation which can deliver so much of what is desired by consumers is there massive dissatisfaction with the health care system? The answers, in good part, lie in our fragmented, clumsy, expensive and unplanned system. It is a system that champions entrepreneurism over provision of basic services.

It provides expensive technology and procedures over prevention and public health. We spend, and spend and spend, but rarely does this Nation examine in a fair, comprehensive or rigorous way, the

quality of what we buy and whether or what we spend is worth the cost.

Saddest of all, and I think this is a terrifying statistic, for $600 billion, the United States has been unable to construct a system that guarantees all Americans access to basic services.

The ability to deal with these questions is not new. In the days of that well known creeping socialist, Otto von Bismarck, the Germans constructed a system of national health care insurance. After World War II those conservative Britain established a program of national health care which has worked throughout time.

In the heart of the American system is the private health insurance industry. While performance of some companies has been exemplary, no one can claim that the industry has met the needs of all Americans.

Indeed, what we will hear today is that many of those who most need the protection insurance offers are least able to obtain it; often they cannot afford it and simply will not remain unprotected. Those who most need coverage for a particular condition or procedure are often denied it.

We will also receive timely testimony today from experts who have concluded that the only rational way to assure health care for all Americans is through a national health insurance system. I agree with this goal, and have annunciated it at the beginning of every Congress for the past 34 years by introducing a national health insurance bill.

The bill looks back to the vision of Senators Murray and Wagner and Congressman John Dingell, my dad, and also to the wisdom of Franklin Delano Roosevelt who intended that we should have such a program in 1936.

It also looks forward to a day when this Nation will muster the collective will to do what Dr. Reinhardt, one of our distinguished witnesses, has often termed, "joining the civilized nations of the world."

America will not have national health insurance this year, and I don't think we will have it next year. The job of constructing such a program is enormous, and it is clear from the experience we have had that such effort will not immediately satisfy everyone completely. But it is clear that the battle must go on. It is also clear that the attempts to provide adequate and decent health care for all of our people will depend on ordinary citizens, business people and providers of care, stating loudly and clearly that they are ready to take a few needed bold steps.

Meanwhile, while we are trying to construct a more rational system of delivery of health services to our people, there are many programs for providing health care that need to be protected. There are also steps that need to be taken to bring about a quick halt in abuses in the area of health insurance. These abuses must be stopped.

Today's hearing is a part of the process of enlightenment that all of us must undergo if we are going to promote the goal of quality care for all Americans.

I want to thank you, Mr. Chairman, for convening the fine array of witnesses we have before us today and to wish you success in your hearing.

Mr. WAXMAN. Thank you very much, Mr. Dingell. Our first panel includes two private citizens, who will describe how they have been seriously affected by the current health insurance system.

Before I introduce the people who have so generously agreed to share their experiences with us, I must comment that stories such as the ones we are about to hear are becoming more common all the time. I am receiving more and more mail describing similar situations.

In each case, people end up heavily in debt for medical bills, even though some had every reason to believe that they could count on having their health insurance pay if they got sick.

Kayleen Anderson joins us from Silvis, IL. She works just over the border in nearby Iowa. Kitty McCague lives in St. Louis, MO. I want to welcome both of you to our hearing this morning. I think your personal experiences and your willingness to share them with us will be very valuable to the subcommittee and to the evaluation of what we ought to be doing to correct the health care problems in this country.

Ms. McCague, why don't we start with you.

STATEMENTS OF KITTY McCAGUE, ST. LOUIS, MO; AND KAYLEEN ANDERSON, SILVIS, IL.

Ms. MCCAGUE. Chairman Waxman and subcommittee members, thank you for inviting me today to testify on my experiences with our country's health care system. I live in St. Louis, MO.

At 38 years old, I owe close to $150,000 in medical bills for cardiac and spinal surgeries and complications. While I am employed fulltime, I am basically uninsurable for these conditions and find trouble finding adequate health care. Unfortunately, my scenario is not unique to other Americans.

Two years ago, I was admitted to the hospital dying of endocarditis, which is an infection of the lining of my heart. A few months before this, I had quit a very good job because of health problems and I lost my health care coverage. Although my condition worsened, I only sought services once, since I had no insurance. That visit ended as I walked out of an emergency room when they said I only had the flu.

A month of intravenous antibiotic treatment was unsuccessful, and I had to have my heart valve taken out in order to save my life. A fake one could not be put in because surrounding tissue was too damaged. So, I left the hospital a month later not really knowing how my heart would hold up without a valve. The procedure is rare, and there is very little medical documentation or history on this procedure and I needed constant monitoring.

I moved back to my home in Texas and soon had a good job with full health benefits under a group plan that did not ask about my medical history. A severe backache soon sent me to doctor after doctor who couldn't find the source of my pain. Again, I quit work and was out without insurance or an income. The local public hospital had no orthopedic department so my condition worsened.

Finally, orthopedic surgeons in nearby San Antonio discovered the infection that had been in my heart was now in my spine. It

had eaten two vertebrae and the disc between them. Three days later I had emergency spinal surgery and a fusion. After 2 more months of intravenous antibiotic therapy, I left the hospital in a back brace that I would wear for 6 months.

I had no income or insurance for conditions which still needed treatment. Although I had battled this disease for 9 months and would be disabled for at least 6 more months, the Social Security Administration rejected my claim and appeal saying that I was employable. During this whole saga, I received no Medicaid benefits.

Last summer I moved to St. Louis to job hunt because the Texas economy was so poor but my health started deteriorating. I was having congestive heart failure because I lacked a heart valve. In St. Louis, I soon learned the public hospital is no place for someone like me with severe chronic ailments.

Fortunately, I found a primary care physician at a federally funded clinic in St. Louis, but she admitted that getting adequate care for my problems in St. Louis would be hard. I may need a valve put in sometime later this year, but we are not sure.

Fortunately, my doctor and others I know at St. Louis University pulled some strings and cardiologists there agreed to see me for free. One reason the cardiologists will see me for free is that my condition is so rare that they are still writing about it. So, I make a good case study although I really appreciate their free care. The university doctors I have had very good luck with them. However, most people, as we know, are not as lucky as I am. I work in health care so I know a lot of people.

Meanwhile, I got a job that provided benefits, but I had to get an individual policy since my company was too small for a group plan. I looked around and found a few options. Two plans said my medical history would disqualify me and another said that if accepted, my preexisting conditions would not be covered for some time. But, these are the very conditions I need coverage for now.

Finally, I found a staff model HMO that was established by one of my board members. I asked for an application, wrote his name on it, but omitted all references to my cardiac and spinal problems although I know the consequences of this.

While I technically have coverage as of last week for some much needed dental care, I still cannot get care for my serious medical conditions. Now there's a possibility that the infection has moved to another part of my spine and I need orthopedic care. This time, I don't know anyone to pull strings for me.

In order to see an orthopedic surgeon 2 weeks ago, I had to spend a day in the emergency room, put down a $50 deposit and sign financial agreements. My bill for the day approached $600. I also have to pay for subsequent visits to the orthopedic clinic, if they will even see me without insurance. We don't know this yet.

My scenario is better than others in St. Louis. Other hospitals there require hundreds of dollars up front to be seen without insurance. I know, because I work on health care issues for indigent people.

So now I am faced with my medical nightmare, not knowing if I need a valve operation in my heart and not knowing if the infection is still in my spine, and knowing that my insurance will not

cover any of this. Although I technically have insurance it will not cover these conditions.

Since moving to St. Louis in August, I already have thousands of dollars in medical bills and my prescriptions alone cost more than $100 a month. So much of my energy is spent seeking health care and manipulating the system that I have little energy for anything else. Fortunately, I have a wonderful job with people who understand my predicament and they give me a lot of slack.

Everyone, particularly myself, is better off if I keep working but I need to stay healthy. I need insurance and need access to affordable quality health care. It makes no sense that I can work full-time but cannot get health insurance. It costs all of us more money if people like me wait until critically ill to seek care in an acute care setting.

We have to start getting serious about preventive medicine such as physicals and primary care and prenatal care. I guess it all comes down to one thing; we have to ask ourselves the hard question. Should our health care system be profit motivated or people oriented.

[The prepared statement of Ms. McCague follows:]

PREPARED TESTIMONY OF KITTY MCCAGUE

Chairman Waxman and committee members, thank you for inviting me to testify today about my experience with our country's health care system. The fact that I owe almost $150,000 in medical bills would be almost comical if it wasn't so representative of what's wrong with our country's health care delivery system. And tragically, my situation is not unique.

Two years ago I was carried into an emergency room of a health maintenance organization in Michigan with an acute case of endocarditis, an infection of the lining of my heart. A few months earlier I had quit a very good job because of my health problems. I started receiving unemployment insurance, but quit going to the doctor although my health worsened because I had no insurance. Like others without insurance, I waited until my situation was critical before seeking care again. I had about 2 days to live when initially admitted to the hospital.

After 3½ weeks of ineffective antibiotic treatment, I elected to have open-heart surgery. A growth the size of a ping-pong ball had diseased one of my heart valves and I needed it removed to save my life. Surgery was successful and after 4 more weeks of intravenous antibiotic therapy, I went home and began to move back to Texas where I grew up. I was anxious to get my life back in order.

I got a good job in Austin and health care coverage under a group plan which did not query me about my medical history. Soon severe backaches sent me to doctor after doctor who could not find the source of my pain which got progressively worse. Once again I quit work and was without health insurance, or an income. A friend from San Antonio offered me a job and I accepted, convinced my back pain would subside and I could work. Unfortunately, that didn't happen.

After a couple weeks I was back at the doctor, this time with an orthopedic surgeon who said the infection that had been in my heart was now in my spine. It had eaten parts of two vertabrae and the disk between them. A few days later I had emergency spinal surgery and a fusion. I left the hospital after 2 more months of intravenous antibiotic therapy, in a back brace which I would wear for 6 months. I had no income and couldn't work for some time. The Social Security Administration denied my claim although I had been battling the disease for 9 months and would be disabled for at least 6 more months. They said I was employable.

But who would hire someone in a back brace with a medical history like mine? By this time, my medical bills were well over $130,000 and I still needed consistent monitoring by both cardiac and orthopedic doctors. Because of my financial situation I began looking for a job and doing freelance writing and editing. But the Texas economy was too slow. I came to St. Louis where I now live and after a few months had a great job that utilizes my skills in community organizing and politics. And appropriately, this time I would be working on health care issues. I know I am blessed to be working again, particularly with people who understand my medical

problems and support me. They realize it gives me an insight into our health care system that others don't have the opportunity to see first hand.

When I was first hired my boss told me to shop around for health insurance which the organization would pay for. Since I was the only employee on my side of the State, I would have to get an individual policy. Phone calls around St. Louis yielded few options. First, there were only a couple individual plans and they told me upfront that my medical history would disqualify me. Another told me that if I did receive insurance it would not cover my preexisting conditions for some time. But these are the only medical problems I need to see a doctor about. Finally I found a staff model health maintenance organization which was founded by one of our board members. I requested an application. But after looking it over, I knew I would be disqualified if I was honest with my answers.

I returned the application without mentioning my cardiac and orthopedic problems. If accepted, I thought, at least I would have some much needed dental coverage and medical care in the event of another health problem. Or would I? I know if the HMO finds out about my omissions, I will be dropped and liable for any bills I incur. And either way, I still don't have health care coverage for problems that need to be constantly monitored. The lack of a tricuspid valve in my heart is fairly uncommon and I may need a fake valve put in sometime soon. Without one I now have ongoing symptoms of mild congestive heart failure, and serious liver problems from disturbed blood flow dynamics.

My heart condition requires frequent visits to cardiologists at St.Louis University Hospital who have agreed to see me for free. Because of my work on health case issues, I know some of the "right" people who pull strings for me. But most other people with serious health problems don't have this luxury; Americans shouldn't have to know someone in order to receive quality, affordable health care. It's just not a good way to run our health care system.

My spinal problems, however, are more indicative of what people without insurance experience. There's a possibility the infection I had is still in my spine and I've had severe back pain recently. I know from experience I need to see an orthopedic surgeon, but this is difficult and costly without insurance. Because the university's emergency room is also as trauma center, I spent a day there recently being seen for my spinal problems. However, I had to put down a $50 cash deposit and sign financial agreements before a physician would see me. The visit yielded little, except some very expensive x-rays and other tests and an appointment next week with a orthopedic surgeon. Seeking care in the emergency room was the only way I could get into their system. This seems like a backwards, and expensive, way to access health care and certainly not in line with any serious attempts at controlling costs.

Our health care system is seriously ill and in need of a major overhaul. It seems illogical and counterproductive that a person who is healthy enough to be employed fulltime is not healthy enough to get insurance, particularly for conditions that need to be monitored. Everyone is better off if people like me continue to work and pay taxes. But if I am unable to receive care for health conditions that could have been kept in check, I will once again become too ill to work. Then everyone starts paying the price. We have to look at long-term solutions and ask the ultimate question—should our health care system be profit motivated or people motivated? Should our health care system exist to line the pockets of insurance companies, hospitals and some doctors, or should it serve the public good and ultimately the interest of our Nation?

And if our country is serious about controlling spiraling health care costs then we have to change the way people seek health care. Once again this brings up the profit versus people question. It costs all of us more when people wait until they are critically ill and seek care in an acute care setting, not only in dollars but in terms of human lives. Encouraging preventive medicine such as physicals and prenatal care would save all of us money in the long run. There are those here today who say this country cannot afford health insurance for all its citizens. I say we cannot afford not to. We have to get serious about what's really vital to the future of our country. Our country was founded on the individuality and stamina of its people. Without a healthy citizenry, how can we survive?

Mr. WAXMAN. Thank you very much. Ms. Anderson, we will hear from you now.

STATEMENT OF KAYLEEN ANDERSON

Ms. ANDERSON. Thank you, Mr. Chairman and members of the panel, for inviting me here to speak today.

I am employed at Project Assist, a dislocated workers center in Davenport, Iowa. Our program is federally funded through JTPA Eastern Iowa Community College. I assist unemployed people to find fulltime, unsubsidized employment. I see the need daily for a national health care program especially for people between the ages of 30 to 50 who haven't any dependents.

I also work with underemployed people who can't afford to pay for private sector health care on their own. There are people who can't accept employment offered to them because they would lose their public aid benefits and be without health care for their families.

I just recently got married. This is the first time in 5 years that my daughters and I have had health care insurance. The agency that I work for does not offer health insurance and the cost of private sector insurance was too high. Do any of you know what it is like to have sick children that need medical attention and not be able to afford it for them? Do any of you know what it's like to have a hospital turn you away because you haven't insurance?

I have several incidents that I would like to share with you. Four and one-half years ago, my youngest daughter, Carrie, bit into an electrical cord. She received burns on her face and the left corner of her lip was gone. After healing, it was recommended by the family doctor that she see a plastic surgeon.

An appointment was made and the plastic surgeon recommended that Carrie have lip reconstruction. I stated that I did not have insurance and his reply was to let him know when I did get insurance. Surgery, at that time, could be scheduled. The doctor also stated that this needed to be done within the next 5 years or before Carrie was 10. Standing there looking at the doctor, I told him that I would call back soon, not realizing that it would be almost 5 years before I would have insurance to fix my baby's lip.

Just 4 years ago, I was working two jobs, one fulltime, one parttime, just to make ends meet. My oldest daughter, Suzy, had been sick often with ear infections for over a month. Not being able to afford the cost of an office visit, I was calling the doctor for a refill on her medication.

While getting ready for work one morning, Suzy came in complaining of not feeling well. So many things run through my mind. If I take time off, that's one day's pay. If I find someone to take care of her, will the care be as good as mom's. This is just part of the guilt I have felt trying to work and raise two little girls by myself. Neither one of my jobs offered benefits.

Looking there at my daughter I knew she was seriously ill. Her joints were swollen, her knees were so big she could hardly walk and she was burning with fever. Three days later, after a series of tests, Suzy was diagnosed as having rheumatic fever with a detectable heart murmur. All this was caused from strep throat that was not treated.

The ear infections that Suzy had been having was an additional problem. If I would have had insurance or had been able to afford

a doctor, all of this could have been prevented. My daughter is now taking medication and will continue to do so until the age of 21.

I have contacted insurance companies about health care. The cost per month is $218 to $280. How can people afford this? The very reason I need health care was because of Suzy. An insurance company wanted to put her on as a rider for 2 to 3 years. If she had had problems in this timeframe, the rider policy would be extended.

The last 4 years without insurance have been a nightmare. Suzy has had three heart flutters and has been in the hospital emergency room three times. It is always the same questions. Do you have health insurance? Just how do you plan on paying for this? We would admit her, but with no insurance we are sending her home. Watch for these symptoms and if she has any problems call us.

Let me tell you, the last thing on your mind is to call someone when your daughter is holding her chest, turning gray and passing out. Living 22 miles from the nearest hospital, your instincts tell you just to get going. Three times I had the doctor's call in medication for the girls because they knew I couldn't afford to pay for an office visit.

The tables have turned and times have changed, I now have insurance. I can call the doctor and they will give me an appointment the same day. Office personnel is nicer. They have quit asking me just how much I can pay and just how long it will take me to pay off the balance. These questions are embarrassing and degrading. People are human beings with feelings, and most are trying to do the best they can with what they have. Health insurance is a need for all humans and not just a privilege for a few.

Thank you.

Mr. WAXMAN. I want to thank both of you for your sharing with us your personal stories, most eloquently explaining why, even if you work, you don't get the coverage you need. You are forced to quit your jobs for your health problems, then you go back to work after you are feeling better, and you get insurance but it doesn't cover your problems.

Most people think everyone has health coverage. After all, we have Medicare for the retired and Medicaid for the poor, and the people who work have insurance at their job. But the reality is that there are a lot of people who are working just as hard as other people who are working their jobs, but they don't have health insurance available to them. Then when they do have it available to them, it has all these exclusions for preexisting conditions or other reductions in benefits and when you recognize that you need it the most, it's not even there to protect you.

I thank you both for your testimony. I want to call on my colleagues to see if they have any questions they want to ask you. I think you have given us, from your experiences, the essential point of why we are here. Even with working people we aren't covering them and their families for their health care needs.

Mr. Nielson.

Mr. NIELSON. I don't have any questions, Mr. Chairman. I want to thank the witnesses for very fine testimony.

Mr. WAXMAN. Mr. Scheuer.

Mr. SCHEUER. Mr. Chairman, I wish to thank the witnesses for their very touching, very compassionate, very moving testimony.

Mr. WAXMAN. Dr. Rowland.

Mr. ROWLAND. Mr. Chairman, I want to thank the witnesses for coming in also and the statements that you have made. Any physician who refuses to see a person who is sick or injured because they are unable to pay violates the oath that he took and should be called to task for having done that.

Thank you, Mr. Chairman.

Mr. WAXMAN. Mr. Dannemeyer.

Mr. DANNEMEYER. Thank you, Mr. Chairman. Kitty McCague, I don't know whether you are aware of this requirement in the Missouri law, but I understand you are from Missouri, is that right?

Ms. MCCAGUE. I've been there about 7 months, yes, sir.

Mr. DANNEMEYER. One of the problems that we have in our society today in terms of the ability of a consumer like yourself to get health insurance is that our State legislatures have, as a result of pressure from groups who want to expand the areas that will be covered by existing policies, have placed requirements on the sellers of health insurance by law in the State that they have to cover people for many things that most people don't need in terms of the type of medical treatment that you found yourself in need of.

I think we have to face up to this. I am not saying that those State mandates are undesirable. The question our society has to ask is: should the basic consumer of health insurance like yourself who wants coverage in case of an automobile accident be required to factor in the premium you would be required to pay.

All of these other mandated benefits that somebody in the State legislature in Missouri felt everyone who has health insurance in your State should have. I just want to mention this to you. I suspect that you are not aware of this. A study by the National Center for Policy Analysis concluded that State mandates in Missouri rendered health insurance inaccessible to almost 30 percent of the State's estimated 714,000 uninsured persons.

When you tried to get health insurance, what did you find you had to pay for it?

Ms. MCCAGUE. I found I could not get—I work for an organization where we only have two staff people, because we are a Coalition of Labor Organizations and Community Groups. Basically, they say go and get an individual policy and we will pay for.

But my preexisting conditions, first of all, I could only find a couple of individual policies. Over the phone one told me, sorry, your medical history disqualifies you. So, there is a lot of discrimination, I think, toward individual plans where if I had gone to Monsanto which is in St. Louis or a large organization you get picked up under a group plan and they don't even look at your medical history.

During my research I found that this staff model HMO—and I only got coverage there because one of our board members helped found the HMO. I am sitting here today testifying that I omitted all this stuff on my application. So it was fraudulent. I will admit that. A lot of people have to do that.

Basically I did that because I knew that if accepted, my preexisting conditions wouldn't be covered for a while anyway. So if I was

accepted, which I was, at least I would have some needed dental coverage and coverage in the case of another type of medical emergency.

It's hard for me to go to a doctor and have even a physical and have him not see scars that I have from heart surgeries and spinal surgeries.

Mr. DANNEMEYER. Do you remember what was the premium that was quoted to you?

Ms. MCCAGUE. It was about $80 a month. Under the HMO it's about $80 a month, which is fine. It's just that I can't get coverage for my existing conditions which is sort of senseless to me. If I am healthy enough to work fulltime, it makes sense to keep me working and paying taxes.

Mr. DANNEMEYER. What does the HMO do; do they exclude coverage for those preexisting conditions?

Ms. MCCAGUE. No. I am saying that I lied and omitted all information about that. I know that's illegal and that I am liable for bills that I incur. I realize that, but I gambled. When I called Blue Cross and Blue Shield they said over the phone, if we do accept you, your preexisting conditions will not be covered.

This was a few months ago but they will not be covered for 6 months to a year. I need care right now. As you see, my problems are ongoing and I need coverage.

Mr. DANNEMEYER. Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you both very much. You have been very helpful in outlining one of the serious parts of the inadequate medical coverage in this country.

We will now hear from Lou Harris, from Louis Harris and Associates and Professor Robert Blendon about their new Harris Poll on attitudes toward health care. Lou Harris is no stranger to the subcommittee or to the American public. His polls tell us all we ever wanted to know about ourselves.

He is accompanied by Humphrey Taylor, President of Lou Harris and Associates, Inc. Bob Blendon is also well known to many of us. For many years, he helped guide the remarkable work of the Robert Wood Johnson Foundation and is now Professor and Chairman of the Department of Health, Policy and Management, Harvard University School of Public Health.

We are pleased to welcome the two of you to our hearing this morning. Your prepared statements will be put into the record in full, and we would like to ask you to summarize your testimony to us or present it orally in 5 minutes, please.

Mr. Harris, we will hear from you.

STATEMENTS OF LOUIS HARRIS, LOUIS HARRIS AND ASSOCIATES, INC.; AND ROBERT J. BLENDON, CHAIRMAN, DEPARTMENT OF HEALTH, POLICY, AND MANAGEMENT, HARVARD UNIVERSITY

Mr. HARRIS. Mr. Chairman, it is a pleasure to come before you once again. Over the years, you have been more than kind to open your committee to allow the sunlight of what the American people really think to be reported so forthrightly here.

In our testimony, Dr. Blendon and I have reported that in our joint survey in the United States, Canada and the United Kingdom, clearly the greatest failure of confidence in the existing health care system can be found in this country, the United States. Only 10 percent of our people think the health care system is okay and needs only minor changes. Eighty-nine percent feels it needs an overhaul, compared with 56 percent in Canada, for example, who feel their health care system is working well.

Forty-four percent of our people are not happy about their last experience with a doctor here, compared with only 27 percent in Canada. Only 35 percent of all Americans are very satisfied with the health care services used by their family, compared with a higher 52 percent who felt that way back at the beginning of this decade in 1980.

The 1980's indeed, have been a time of disenchantment by our people, Mr. Chairman, with their health system. A substantial 37 million Americans as has been cited over and over again this morning are simply not covered by any health insurance today. Two-thirds of that number, 24 million report that they could not get the health care they felt they needed just in this past year, 14 million just couldn't afford it.

In Canada, comparably, just less than 1 percent reported the system had failed them. We have a condition here where we spend more per capita than the United Kingdom or Canada, yet, we are also vastly more unhappy and dissatisfied with our system than either country especially Canada.

The real shocker, of course, is that when asked to choose between a totally nationalized health care system in the United Kingdom or the United States system or national health insurance as in Canada or in this system, the system in the United States is a mixed system of public and private insurance, 61 percent of all American prefer the Canadian system to ours while 29 percent prefer the British system. Less than 1 in 8 Britains and 1 in 33 Canadians prefer the United States health system.

We simply are not the world's envy on health care. Bluntly speaking, the British are not overly enamored with their system but they stick with it much more than we do with ours. Only the Canadians are basically satisfied with what they have.

Let me hastefully add a note from my personal experience in 1963. Back then Canada, who I was surveying then, there is dissatisfaction with their health system. I polled for Prime Minister Lester Pearson and used to do this for candidates but don't do this anymore. In the 1963 election, I found health care the top issue. People felt the mixed system was not working well, especially that health benefits were not portable. Pearson made health care his cornerstone issue and he won the election.

Some now claim Canadians are less critical and more satisfied with all parts of their life than Americans. Mr. Chairman, that's just plain nonsense. They just might be 25 years ahead of us in health care efficacy. In this survey, and we asked about priorities for government spending, two areas stand out as most urgent; education and health care.

This is not the first time we found that to be the case. Just in the last fall Presidential election, when we asked about the Dukakis

plan of universal health insurance mandated by government but paid for by business, a three to one majority favored such a plan. It is revealing, when we ask about trade offs in government spending, consistently for the past 3 years by four to one in the majority of the public, the people want defense spending cut and health spending increased.

Just this past week, in fact, just this morning, a national public radio reported that programs to help the homeless AIDS victims, those affected by acid rain and toxic waste, all areas where health is vitally affected, they get a big priority of two to one or better over such areas as increased spending for SDI or the bailout, for example, of S&L's and a number of other areas I can tick off where the Bush administration has asked for more spending. The President, of course, has asked for more spending on homeless, AIDS victims, those affected by acid rain and so on.

Normally, Mr. Chairman, we Americans instinctively stand tall about the U.S.A. We have fierce pride in our country. Certainly, I felt that way and my generation did when we fought in World War II. Sight unseen, would give our country the benefit of the doubt when we compare an institution here in this country with those in other countries. That is decidedly not the case with health care.

Obviously, the situation is seen as urgent and even desperate in the case of our health care systems. This, I would suggest, is a powerful message here. It is this: The great unfinished business of this country is to overhaul our health system. Make no mistake about that. People are just as upset at cuts in Medicaid as in Medicare, for example, because we have compassion about health care for the least amongst us.

We demand and want universal health coverage in this country, we want to utilize the best that exists in the public and private sectors. Above all else, we are demanding a system of national health insurance. The American people want a governmental presence in national security and fighting drug abuse and child care and education and caring for the homeless and in guaranteeing and providing health care.

Those who would claim to the contrary court the wrath of no less than the people themselves. So, good luck in your mission to address this most urgent cry for help for no one less than your own constituents, the folks back home. Please heed what they say sooner, not later. They feel the hour is late, the urgency is quickening. Seize the nettle now, and the response you will get I guarantee you, will be the sweetest wind, the most welcome flood tide you can experience in public life.

Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you very much, Mr. Harris. Dr. Blendon.

STATEMENT OF ROBERT J. BLENDON

Mr. BLENDON. Everybody doesn't need me to say that was a tough act to follow. Let me just take a couple of minutes to give you a history of the study and highlight a couple of the points from Mr. Harris' remarks on the survey.

First, the Baxter Foundation approached both of us and asked whether or not it was possible to do a survey which would be useful

to the new administration and Congress as well as to the new government in Canada. We pointed out to them that though we had a Nation full of experts on these issues, no one had ever asked the average American, Canadian and British together, just how they personally felt about their own health care.

Though we have thousands of surveys, it turns out no one had ever done it, and we suggested they do it. What we have before you is results of questions, many of which were tested in earlier studies within the United States but never asked before other groups. Let me just hit the issues again.

The dissatisfaction levels with United States health care system are astronomical in comparison to that of a nation like Canada. On every way you ask the question, Americans manage to find themselves more dissatisfied than Canadians.

Second, if you look across the British, the United States and Canada—and let me say objectively, the health system in Great Britain is in so much trouble, it would be impossible for me as a researcher to believe that anyone would answer the questions the way they did. Yet, what you find is a loyalty to the national health service in Great Britain, which is just from a research point of view, is speechless. The British want something done that's differently but they don't want the United States' arrangements.

In terms of actual care experience, this is what we found. Everybody is reasonably satisfied with their medical care when they are sick, except Canadians are significantly more satisfied than Americans are across every aspect. Ask them, how about your family care last year. Canadians are much more satisfied. How about the physician visit you just had when you were sick. Canadians are more satisfied than Americans.

The myth, I happen to believe as many of the members on this committee that actually the U.S. health care system had special features. I insisted that we ask once and for all, whether or not, people across the world believe we either have the best health system or don't. What you find is very simply, not only that only 3 percent of Canadians see any value in the American health system and 12 percent of British, but we sat there and looked for 2 weeks at the results and tried to explain why 61 percent of Americans, many of whom had never seen Canada would, in looking at a paragraph about the Canadian health care system say I would rather have that than what I have today.

By the way, for those of you who say they don't know enough, they knew enough to say in no way do I want the British national health service. Americans totally rejected the idea of the British national health service.

What surprised us, as researchers, is that they also rejected what most of us do with our days. They said they would try something up North that sounded better to them that goes on in a day-to-day basis. That is incredible from a research point of view.

Mr. Harris hit this point. I have been at work with the research people in polling. Americans are terribly patriotic. Regardless of how much they have suffered, having now gone through 500 polls on this question, they will never with their arms twisted behind their backs, ever say that a better system exists in any other country for any other reason.

So you have a degree of frustration and anxiety untold in the research literature and polling. Let me deal with one other question which Newsweek provided us. I know we like to say Harvard did this. It is a question, can you afford medical care. We asked it in the three countries. This is what we found. Seven and one-half percent of Americans said last year, just like the people who testified, I could not get the medical care I needed because of money.

This answer in Canada and Great Britain was one-half of 1 percent. This question, they could not have sold Newsweek in Canada that week. The people we interviewed didn't know what we were talking about on the telephone. We have a problem which you can pick up on surveys which does not exist.

Let me just close by saying that I expect this is a financial insecurity issue. Having spoken to the Board of the American Medical Association, most of them said it can't be physicians that are the problem here. I expect it's a problem of financial insecurity, and I think in Mr. Harris' testimony that's exactly what we emphasized.

I want to close with the fact that we do have something wrong in the American system which everybody out there you interview knows about which must reflect itself in the day-to-day physician and hospital care. We have people who say I will choose something up North rather than what I have now and tell me about my health care and I will tell you that it's not as good as somebody else's.

There is some underlying tension going on in the American public, and compared to other countries that probably suggests a major change in public view about what to do about this issue.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Blendon follows. The article referred to from the Health Management Quarterly has been retained in subcommittee files.]

TESTIMONY BY ROBERT J. BLENDON, HARVARD UNIVERSITY SCHOOL OF PUBLIC HEALTH

Mr. Chairman, I would like to thank you for inviting me to testify today. My name is Robert J. Blendon, Sc.D. Currently, I am professor of the Harvard School of Public Health. In addition, I serve as deputy director of Harvard University's Division of Health Policy Education and Research. Prior to this appointment, I was senior vice president at the Robert Wood Johnson Foundation in Princeton, NJ.

In recent months, many private- and public-sector leadership groups have become increasingly concerned about the performance of the U.S. health care system. Sharp increases in the cost of health care, accompanied by a growing population of uninsured Americans, have become an American reality. As a result, the public's faith in the effectiveness of current government and private-sector initiatives to contain costs has been shaken. Many experts question whether any set of incremental policies can adequately address America's seemingly intractable health care for its citizens.

The intensified search for new directions in U.S. health policy has led to renewed interest in learning more about the experience of other industrialized countries in managing their health care systems. This interest has been reflected recently in several media reports and in health policy journals.

Attention has focused particularly on Canada and Great Britain, our sister English-speaking nations, and on comparative studies of the medical care organization, financing, statistical performance, and the general health status of citizens in these countries. Canada has a system of national health insurance with rates for services set by the government. Great Britain's National Health Service employs doctors and runs hospitals.

To date, what has been missing in these analyses is any comparative study of how the people of these three nations feel about their experiences in obtaining medical care, and their views of the performance of their own health systems. In the fall of

1988, Louis Harris and Associates, in conjunction with the Harvard School of Public Health, undertook to examine these issues for the Baxter Foundation. The study was directed by Humphrey Taylor, president of Louis Harris and Associates, and myself. For the first time ever, adults in the United States, Canada, and Great Britain were surveyed simultaneously as to their views on these important issues. While the results of this comparative study do not provide in-depth answers to many questions, they do give clear indications of different patterns of access to and use of health services in each country, satisfaction with each nation's health system, and suggestions of directions for future health policy in the United States.

In summary, the results show: Eighty-nine percent of U.S. citizens said their health-care system needs either "fundamental change" (60 percent) or "complete rebuilding" (29 percent);

Canadians have a dramatically higher regard for their health-care system. Only 38 percent of them said "fundamental change" is required and 5 percent said there is need for a "complete rebuilding;"

Results in Great Britain fall between those in the two North American countries, with 69 percent saying their National Health Service needs significant change (52 percent for "fundamental change" and 17 percent for "complete rebuilding");

Americans are significantly less satisfied with their own physician care experiences than Canadians. Only 54 percent of Americans reported being "very satisfied" with their last doctor visit, compared to 73 percent of Canadians and 63 percent of the British. With respect to recent hospitalizations, 57 percent of Americans were very satisfied, 71 percent of Canadians and 67 percent of the British;

Low-income Americans receive significantly less physician care than do similar Canadians. In this survey, 7.5 percent of Americans (representing 18 million people) reported not receiving needed medical care for financial reasons, whereas less than 1 percent in Canada and Great Britain said they could not obtain medical care for financial reasons;

Thirty-six percent of those Americans ho said costs were a barrier to needed medical care said they were uninsured. The other two-thirds who could not afford health care were insured, suggesting that many people have inadequate insurance coverage;

There was almost no difference in the number of visits made by Americans, Canadians and British to doctors' offices, outpatient clinics, emergency rooms or other care providers despite the differing financial systems. The mean number of visits was seven in the United States, six in Canada and five in Great Britain; and

Citizens of all three countries said they wanted more government funding of health care. In the United States 24 percent gave highest spending priority to health care, second only to the proportion who ranked education (34 percent) as their top priority. Defense spending was lowest on a list of five categories (defense, education, health care, housing, and social security) with only 9 percent, ranking it as their first choice for spending.

Mr. WAXMAN. Thank you very much, Dr. Blendon. Mr. Harris, Mr. Blendon made the point that usually Americans will say that the American system is better than any other. Here we have Americans saying, in fact, they prefer a system like Canada's.

Is it unusual to find this kind of a separation on something that is foreign?

Mr. HARRIS. Mr. Chairman, it is very unusual. Most Americans have a preset orientation to say we are better than other places. Most Americans like to live here. This stands out. This stands out, to be blunt about it Mr. Chairman, as a real sore thumb. I have to say that.

Let me say I don't think, Mr. Chairman, this would happen—I've been in this business a long time and I guess 15 years ago we wouldn't have gotten anything like it. I think it has been a deterioration. I have a key suspicion as to why this is happening.

Just this year, for example, we have had an increase in inflation as you know, and leading it as always is health care cost increase. They are soaring now to an estimated 34 percent this year. People finally reach a point like water on a stone of saying look, the cost

is so exorbitant, I can't afford it and I'm not getting my money's worth.

I think probably in terms of just not getting their money's worth, this has probably eaten away and eroded the confidence in the system more than anything else. The fact that you've got huge gaps of people that aren't covered, you can't find the care and don't have access to it just compounds it.

Mr. WAXMAN. I suppose whether someone is happy or not with the medical system has a lot to do with their expectations, and we have different cultural expectations in Great Britain than we might have in the United States.

How do you think that might affect this poll? People could be satisfied with the system in England where Americans would be overwhelmingly dissatisfied, and perhaps the same would be true about the Canadian system. Are their expectations lower than Americans so that they are satisfied with what Americans would be dissatisfied with?

Mr. HARRIS. Let me say the national health care system in the United Kingdom is not burning up the woods with popularity either. I am not a health expert, Dr. Blendon is, and suggest that maybe there's some cause for that. In Canada, which I am quite familiar with and have done a lot of work in over the years, the claim was made and apparently the initial response to this survey was that Americans are more doer and tend to be more critical than the Canadians who tend to be more laid back.

This is nonsense. Dr. Blendon, in fact, brought a whole chart here. You don't mind if I swipe it from you? Here's the expectations on a whole series of things of Americans. Way below that is one from Canada. Canadians grouse a great deal. When we recently signed a trade agreement with them, in the United States it barely made a ripple. Believe me, there is unhappiness in Canada over that.

Canadians probably complain more than Americans do about their status of life in most things. Again, the exception, health care. In other words, health care stands out as one which seems to be the exception to the rule of in America where we say we just are not proud of it, health care in Canada is the exception in that people say we think it is terrific.

Does the fact that Canada has a system of national health insurance make the difference? I suspect it does.

Mr. BLENDON. If I could just add to that, Mr. Chairman. Gallop in Canada offered to help me, because when we spoke in a major press conference this issue was raised over and over again. If you live with the moose and elk, aren't you the happiest people in the world? It has nothing to do with health care.

It turns out that this question here is are you satisfied with the direction in which your country is going? Gallop asked us every single year in an identical way in Canada and the United States, and since 1982 Americans have exceeded Canadians in their confidence levels in the direction of the United States economy and system in general.

Likewise, Gallop asked Canadians and Americans how they feel about their optimism for the economy for the next year. Every single year of the 1980's Americans are more optimistic than Cana-

dians about the future of their economy. So when we ask Americans about their confidence levels in the directions of the country and the confidence levels in the direction of the economy, they find no such cynicism.

It is only when we switch to health care questions that Canadians suddenly become the most optimistic people on the face of the earth.

Mr. WAXMAN. Dr. Blendon, were you surprised by this poll?

Mr. BLENDON. Totally surprised.

Mr. WAXMAN. Why were you surprised?

Mr. BLENDON. First of all, we were very tight in getting this done. Most people believed that academics find in their studies what they are looking for. So, I was forced to write a draft of this paper which is available to anyone who wants it without the data. I had to throw the whole paper out.

Second of all, one, I believe that Americans would never identify with an American system, period. Third, there is objective reasons to believe that the national health service in Great Britain is in terrible trouble. Therefore, I believe that the British would say to us in the survey that we hurt so badly that we make America look great.

What it turns out is that the British like the Blitz, are willing to suffer and have a loyalty to their health care system that I did not realize Americans did not have. I thought the British would be at the bottom. Americans would never acknowledge—and this is from other surveys that were done—that Canada could be better and that we would be in the middle and it wouldn't be as clear a gap.

So, I threw the paper out which was going to say this is a muddled situation. We are between Canada and Great Britain, and you will hear the presentation you have today.

Mr. WAXMAN. You hear about 37 million people who don't have coverage. What do we have, about 250 million people in this country?

Mr. BLENDON. Right.

Mr. WAXMAN. So most people do have coverage. We hear a lot about the health care system in this country being the best in this world. Why are so many of the people that are covered dissatisfied? Is it because they are concerned about those who don't have coverage, or is it an insecurity about their own coverage? Mr. Harris.

Mr. HARRIS. Mr. Chairman, it is partly both. We do have compassion as a country, contrary to what some people may claim. Medicaid is a good example. I alluded to that in my testimony. I am always amazed that support for Medicaid, which is, of course, government health insurance for the poor, gets almost as much support as Medicare which affects people directly, the elderly directly.

I have always wondered about it and we have explored it. We find people just feel in health particularly, our people feel that all people should be covered and cared for. We feel it is inhumane not to do it. The high priority given to AIDS research today in this country, it's a very major issue which people are responding very positively to.

Second though, what you do find is a great many people are covered don't feel that when they go to exercise their privileges as people who are insured, they find it is not quite as much as they

thought it was first. Second, they find that as you saw in some of the witness', the particular ailment that they have somehow is excluded and that seems to be full of loopholes. Therefore, they have had some shattering experiences.

Mr. WAXMAN. Did you ask the question, "are you satisfied with the system" and then a separate question, "are you satisfied with your own personal insurance coverage?"

Mr. BLENDON. Yes, we asked them about their own personal care and then a question about the health care system in general.

Mr. HARRIS. Yes.

Mr. BLENDON. For years, Harris and others have shown that Americans were reasonably satisfied with their own personal care but were very disturbed with the health care system. We expected to find that again.

What we didn't expect to find was the huge gap on both questions with Canada. That is though, Americans are satisfied personally with their physician care and family care. When you stack it up to how satisfied Canadians are, there is a significant gap. The Canadians don't have this answer.

Harris has asked this similar question for almost 15 years to the United States, how do you feel about your health care system. Academics have always reported, gee, Americans don't like their health care system but their care, they are reasonably satisfied with. Suddenly, we go up to Canada and ask the same question and Canadians are not in any way dissatisfied with their health care system.

They were two separate questions. As to the third one, we gave them a paragraph describing each of the other country systems and said is there any chance that you would be interested in this other system.

Mr. WAXMAN. What was the response about whether they were satisfied with their own personal coverage?

Mr. HARRIS. Mr. Chairman, that's gone down 17 points since 1980. We measured on a trend basis. This is a rather precipitous decline. Suddenly this hit a critical mass.

Mr. WAXMAN. Less than a majority? Was less than a majority satisfied?

Mr. HARRIS. Yes. It went down from 52 to 37 percent who said they were very satisfied with their health care here, which is interesting. You can say well somewhat satisfied and adequate. I would say when it comes to health, most people are not willing to say somewhat. They want to be very satisfied or not satisfied.

It is not a question of well maybe this gadget works fairly well and I will live with it. When it comes to health, you are scared to death if it is something less than what you think is excellent and will do the job.

Mr. WAXMAN. I want to call on some of the other members of the subcommittee. Perhaps you can get some of your other points in, Dr. Blendon. Mr. Nielson.

Mr. NIELSON. Mr. Harris, I have several questions.

Mr. HARRIS. Fire away.

Mr. NIELSON. I have done a lot of survey work myself, so I have some technical questions that I am sure you can answer.

First of all, in your survey there's a very brief limited description of the Canadian and British health care systems. I will quote how you are describing the Canadian one. You say that in the Canadian system of national health insurance, the government pays most of the cost of health care for everyone out of taxes and the government sets all fees charged by doctors and hospitals.

Under the Canadian system the people can choose their own doctors and hospitals. On balance, would you prefer the Canadian system or the system we have here. Do you believe that limited description, since it's a very complex health system, do you think that's enough to give the Americans a real good feel for the Canadian system? Do you feel that is sufficient information?

Mr. HARRIS. Mr. Nielson, you left out a pivotal thing we asked and didn't read it. We also asked in Canada and the United State system, the government pays most of the cost of health care for the elderly and poor and disabled.

Mr. NIELSON. No, I'm saying in the question about where they prefer the Canadian system to the United States.

Mr. HARRIS. We asked. What you leave out is that before they were asked that question on Canada, they were also asked the American system question.

Mr. NIELSON. Of course.

Mr. HARRIS. Therefore, when we—if you are suggesting that we are comparing this long explanation of the Canadian system or the system we have here in a cryptic way, no. We are comparing it with a full description which we had before. Shall I read it for the record?

Mr. NIELSON. You mentioned the American system and that's about four lines also.

Mr. HARRIS. Yes, sir.

Mr. NIELSON. The United States system, the government pays most of the cost of health care for the elderly, poor and disabled.

Mr. HARRIS. Right.

Mr. NIELSON. Most others either have health insurance paid for by their employers or have to buy it from the insurance company.

Mr. HARRIS. Right.

Mr. NIELSON. Some have no insurance. Under the United States system, people can choose their own doctor and hospital. On balance, would you prefer this system? That is the one that you are referring to. Yes, you read both, that's true.

My question is, are those paragraphs—of course, they know about their own system quite well—is the paragraph about the British system or the Canadian system sufficient for them to make a judgment on it?

Mr. HARRIS. I would say that, as I understand it is a fair description of the Canadian and the British systems. As you know, if you have read this——

Mr. NIELSON. I have read it.

Mr. HARRIS. By 68 to 29 percent, we prefer the American system over the British system, but we prefer the Canadian system 61 to 37 percent over our own system.

One of the things in survey research you have to watch for is, you get using the same mode of questioning, do you get variable results. We have a perfect, classic result where by 68 to 29 percent

we reject the British system and take our own. But 61 to 37 percent we reject our own system and take the Canadian one. I would say that's a significant result.

Mr. NIELSON. Did you mention, for example, the Canadian tie up would lead to substantially higher taxes?

Mr. HARRIS. Sir?

Mr. NIELSON. Did you suggest to them in the survey that the Americans, they were told that the Canadian system would require a lot higher taxes; was that mentioned?

Mr. HARRIS. We said that it was paid for out of taxes.

Mr. NIELSON. Did you mention it would require longer visits and longer delays to get into the see the doctors in hospitals?

Mr. BLENDON. Sir, there is no research evidence one way or the other. I would gladly discuss this with your staff. There is no joint research about waiting time in Canada or Great Britain or the United States.

Mr. NIELSON. There is an article in the same quarterly that you have that discusses that very definitely.

Mr. BLENDON. There is no data in the article. I think people have the right to express an opinion. It should never be messed up with data, because there is no data on this question about waiting times between the countries.

Mr. SCHEUER. Will my colleague yield briefly?

Mr. NIELSON. Not at this point, I won't. Let me ask this question. Your survey found 89 percent of the Americans see the U.S. system as requiring lots of fundamental change. In other words, you do say 89 percent requires fundamental change, and I think we all agree with that.

Mr. HARRIS. Do you agree with that?

Mr. NIELSON. I don't think it requires fundamental change. It requires some improvement and some cost changing and cost containment. It doesn't require fundamental change. More than 8 in 10—I guess I'm in the 11 percent who doesn't think it needs fundamental change.

More than 8 in 10 however, express that the hospital visit was satisfactory or their doctor visit was satisfactory. How do you explain that apparent anomaly that 89 percent wanted change and yet 85 percent say they were satisfied with their hospital stay, 76 percent say they were satisfied with their most recent doctor visit. Is that a contradiction?

Mr. HARRIS. Mr. Nielson, I think you didn't pick up what I said earlier. In matters of health I would not accept, even though we have a four-part scale here of very satisfied, somewhat satisfied and somewhat dissatisfied, very dissatisfied. On matters of health, we find that people—let me give you an analogy.

If a television show gets a rating of 70 percent very satisfied or less, it's off the air. Now in the case of health care, I would suggest to you sir that when you only get 54 percent who say that their most recent visit to a doctor was very satisfactory, you have quite a wealth of uncertainty and feeling of not total satisfaction.

In other words, to be somewhat satisfied with a visit to your doctor or somewhat satisfied with the experience that you have had in a hospital or whatever, is something less than perfect. In Canada and the United Kingdom, you've got 19 points are more

satisfied in Canada and you have 9 points even in the United Kingdom.

Mr. NIELSON. Let's turn the question around, Mr. Harris.

Mr. HARRIS. Go ahead.

Mr. NIELSON. You only have 13 percent dissatisfied. Look at that side of it, somewhat dissatisfied or very dissatisfied. Yet, there are 89 percent that say it needs a fundamental change. Are they not contradictory results?

Mr. HARRIS. No. I would say that what people are saying——

Mr. NIELSON. From your own data they are contradictory, Mr. Harris.

Mr. HARRIS. I don't think so.

Mr. NIELSON. That says they are satisfied with their visits?

Mr. HARRIS. No, because what I think you are saying is—I have my doctor and I have visited my doctor. I am satisfied, okay. They are saying the system itself needs great change. Nearly 10 percent say this system is working very well.

Mr. NIELSON. And yet, nearly 85 percent say they are more than——

Mr. HARRIS. Mr. Nielson, let me tell you what is missing and what you leave out of your analysis.

Mr. NIELSON. I am using your numbers.

Mr. HARRIS. Do you know what it is? C-O-S-T, cost. Cost, cost is one of the major reasons people are unhappy with this system. They are very happy with their doctor's care.

Mr. NIELSON. There's nothing in your survey that relates to cost. Not one thing in it. Cost is not mentioned anywhere in here.

Mr. HARRIS. I will give you until it comes out of your ears, if I might suggest something, it is cost. We have probably done 2 or 3 million per year research for the Robert Wood Johnson and other foundations on cost of health care.

Mr. NIELSON. My time has gone, but I would like to have another round because I've got seven or eight more questions.

Mr. BLENDON. Can I get one line in on this one?

Mr. NIELSON. Sure.

Mr. BLENDON. When longer questions are asked in the United States, and there are published pieces on this about the satisfaction with the visits, what breaks out is the cost issue emerges as a major reason that people say in the visit they are not satisfied.

So I believe, looking at other surveys—you recall this was the first done across lines—that what you have is a concern about the cost issue within the visit and not necessarily measuring whether or not the quality of what the doctor did was any better or worse between the countries.

Mr. NIELSON. I would concur that we need to ask about cost, not only the cost of our system but the cost of other systems. I would like to see a survey which compared the benefits and costs. I think that would be very effective. This survey does not do that.

I thank the Chairman for his indulgence. I will yield to Mr. Scheuer.

Mr. WAXMAN. The gentleman's time has expired and it would be Mr. Scheuer's time now. I will recognize him.

Mr. SCHEUER. Thank you, Mr. Chairman. I want to explain to my friend, Mr. Nielson, that when I asked him to yield I wanted to do

that for the purpose for correcting what I am sure was an unintended, erroneous implication when he asked Mr. Harris if in the poll those questioned knew whether the Canadian system was more expensive than the American system.

The assumption is that the Canadian system is more expensive. That is simply contrary to the facts as we know them. We are spending approximately 11 to 12 percent of our GNP on health care. The Canadians spend approximately 8 percent on health care.

To move from the Canadian system to the American system would require an increase of about 50 percent in the per capita health care costs of Canada. This is documented in the New England Journal of Medicine in February 1986. These figures are 3 years old, but I presume they haven't changed a great deal.

Conversely, to move from the American system, where we are paying roughly 11 to 12 percent of GNP for health care, to the Canadian system theoretically could result in a 30 to 33 percent reduction in per capita health care costs for the American people.

We have a very wasteful, ineffective health care system. Were we to shift, were we to segue from our system into anything like the Canadian system, there would be the potential for significant per capita savings in health care expenditures and probably an improvement in health care benefits to the average American.

This is what I wanted to——

Mr. NIELSON. I apologize. May I respond?

Mr. SCHEUER. Of course.

Mr. NIELSON. If you are telling me a national health insurance system would save the taxpayer money and reduce our total cost outlay on health care, I will be the first to join and sign up. But I don't believe that.

I believe that if you look at the letter from Senator Hatch in this Journal and look at other articles, it does mention there is some waste in our system. We need to clean that up. We need to contain costs.

But to initiate a new system and require it, I am sure will cost billions of dollars and even Senator Kennedy's bill was estimated to cost $18 billion when it was first promoted several years ago. I'm not sure that's an accurate figure now. Maybe it's just a shift of costs, maybe that may be true.

But it is going to cost the American taxpayer a considerable amount to adopt it. Now, maybe the cost benefit will still be in that direction, maybe you are right. We need to look at that. That's why I suggested to Mr. Harris and Dr. Blendon, we needed to look at the cost and the benefit of the systems before we come up with a conclusion that we need to switch.

Mr. SCHEUER. I totally agree with the gentleman that we need to look at costs and benefits. But there is a wealth of evidence. I took nine days of hearings in the last year that there would be enormous savings in the order of magnitude of nine figures to the left of the decimal point. That's hundreds of billions of dollars.

Joe Califano and Uwe Reinhardt—Uwe is here and will speak for himself—estimated that 20 to 25 percent of the entire cost of the American health care system could be saved if we rationalized our health care system and eliminated the duplication, the overlapping, the chaos and the gross inefficiency.

Now, you could either save or you can invest some or all of those savings in serving the 37 million Americans who do not now have systematic assured access to our health care system. If we could do that and not increase the gross cost of our health care system, you certainly would have a markedly decrease per capita cost of health care per insured individual. That is what we are after.

We are after providing health care to the entire American public at a rational, cost effective, acceptable way. We are under budget constraints, we don't want to do anything that is foolish or wasteful itself. We are trying to cure waste, not cause waste.

All of the evidence is that going to a national health care system would rationalize our system, would make it more systematic, would fine tune it, would eliminate enough waste, duplication, overlapping, to include the 37 million people who are uninsured at no significant increase and, perhaps, no increase at all in our total expenditures for health care.

Mr. WAXMAN. Thank you, Mr. Scheuer. Mr. Dannemeyer.

Mr. DANNEMEYER. Mr. Harris, maybe I didn't understand what you were saying in your survey. If I understood what you said in your remarks today, you are sharing with us your feeling that the American people believe that the U.S. Federal Government should play a more central role in the health care system in this country. In effect, I think you are saying the Americans are demanding a national health care system.

Yet, when you talk to the American people and you don't tell them up front that the adoption of a system that exists in Canada will result in higher taxes or longer waiting lines to get a service, is that really a valid conclusion that you can bring forward and share with us today?

Mr. HARRIS. Mr. Dannemeyer, we have asked that question. We didn't here, and you get 78 percent who will tell you—I will give you the documentation if you like, that are willing to pay higher taxes to get a better health care system which the government would play a major role in.

This is a precipitous change. I would not be sitting here 3 years ago saying this. This is a change which I suggest is creeping up right behind you and you better look behind you.

Mr. DANNEMEYER. Mr. Harris, I don't quarrel with what your findings say. But do you know what the Congress of the United States would do with new taxes that we, as members of Congress, may enact?

If we would spend the money for the health system your respondents in your survey are talking about, that would be one thing. But I have some news for you, my friend. The probability of this institution spending new tax money for a specific program that particular citizens want is not good. It is going to be spent for something, but there are so many demands by the spenders who run this institution that the probability of that new tax money being spent for health care is not very good.

Mr. HARRIS. Well, you have had a lot more experience than I have in that.

Mr. DANNEMEYER. I have watched it for 10 years.

Mr. HARRIS. Mr. Dannemeyer, that's a judgment and I guess there are others, probably a majority, that disagree with you. I

would say this so, and I want to pick up if I can on your time. I want to pick up on one thing Mr. Nelson said.

Mr. DANNEMEYER. I just have so much time. I would like to ask Mr. Blendon here, do you find it ironic that there is a growing consensus among policy analysts in the United States such as yourself in favor of national health insurance at the very time when a country, which has tolerated a much higher degree of governmental involvement, Great Britain, is moving in the opposite direction?

Do they know something that we don't know?

Mr. BLENDON. First is the study that we did here, if you look at it, it was published in a major editorial in the London Times absolutely suggests that the British people do not want the direction the Margaret Thatcher government is moving in.

Mr. DANNEMEYER. Last time I noticed, her party had a majority in Parliament, didn't they?

Mr. BLENDON. Yes. The answer was the way the government holds is that they cannot respond as the survey shows.

Mr. DANNEMEYER. This is what she proposes: decentralized governmental control over hospitals; give physicians more control over their practices modeled on the American HMO model; and more patient choice over their physicians and care. That is what the Thatcher government is advocating for Great Britain because they have experimented with this program you are suggesting that we adopt.

Mr. BLENDON. I am not endorsing anything about Britain, except that I have had some wonderful meals there. The thing that I do want to say is that we asked the British public without any explanation, here are choices and what do you want.

I am not responsible for the fact that the government of Great Britain does not follow the views of the British people. I am only prepared to say that the British people exactly 12 percent, chose a model like the United States. I can't force the British people to go and change their minds.

Mr. DANNEMEYER. May I suggest that in your future surveys when you want to find the sense of the American public and their willingness to pay taxes for a service, ask the question this way: If you support an increase in taxes for better health care in America, would you favor that increase in taxes if there is a high degree of uncertainty as to whether or not those increased taxes would end up providing the health increase or better health care you want.

Would you then support the tax increase?

Mr. BLENDON. Well, I sure couldn't, but I don't know if anybody else would.

Mr. DANNEMEYER. I think most people are smart enough to say that.

Mr. HARRIS. Mr. Dannemeyer, let me say one thing if I might. This may shock you. In the United Kingdom we have an office, Harris Research, and guess what? We do all the research for the Thatcher government and have for the last 20 years.

You see, we are objective. We are objective. We can do that not with immunity, we can do it because they want to know the objective truth. We do this throughout the world in 80 countries, and that's a fact about the United Kingdom. Check it out with anybody you know in England, if you don't believe it.

Mr. DANNEMEYER. I was privileged to be in Houston and listen to Dr. DeBakey, a famous surgeon there. He described how health care systems relate to the demand we ration by one means or another. In those countries in Western Europe that have adopted national health plans, the way that physicians ration services is by ability of a consumer to get in line to get it.

In this country a surgeon may do six or eight procedures a day. In those countries, a surgeon may do two and they don't find the time to do more because the compensation they receive is less. You may have drafted those doctors in those countries in Europe to serve in a national health care system, but those doctors have a way of responding to their employer, the State, by saying I'm not going to perform six or eight procedures a day because you are not paying me for them.

The point is, people ration services based on compensation and that's the difficulty that any national health care system has.

Mr. WAXMAN. Thank you, Mr. Dannemeyer, for that rhetorical statement. Dr. Rowland.

Mr. ROWLAND. Thank you, Mr. Chairman. This is a lively subcommittee. Mr. Harris, the statement here that only 10 percent of our people think that our health care system is okay should be very, very distressing to everyone who delivers health care in this country.

I am concerned in reading that statement that it might be misleading. I don't have any scientific polls, but as I mentioned earlier, I have a lot of town meetings in my district. Listening to the people there talk about health care, they are concerned about cost and access to care. This is what I mentioned earlier. I hear almost no criticism of the quality of care that is delivered.

When you read a statement like that, it seems to me that it is somewhat misleading. We ought to realize that when we are talking about changes that need to be made in our system, and Lord knows, we need to make changes in our system because cost and access is a real problem.

You talk about how good the Canadian system is, how people in this country feel about our system compared to how people in that country feel about their system. I don't think the people in this country realize, if what I am hearing is true about the Canadian system, don't know about it that they are beginning to experience some malfunctions in that system there where the care is free and the ceilings have been imposed on the funding. They are waiting now, postponing surgery, cardiac bypass surgery, people are dying because they have to wait and don't get the surgery in time or diagnostic capabilities are failing.

Technology such as cat scanning is not available in Newfoundland. For example, only one machine in a population of 579,000 people. The problem that we have with litigation in this country that they don't really have there. As I understand it, in Canada there's a great difference there because the cases are decided before a judge and there's not a jury trial.

The courts are smaller and the lawyers don't take contingency fees. They are not allowed to do that. They get paid a flat fee. There are so many differences in what is taking place in this coun-

try and what's taking place there, it seems to me that kind of answer is very misleading.

I would just like to hear your comments on that, if I may.

Mr. HARRIS. I am not in the position to make a judgment as you are about the Canadian system. I assume that you studied it extensively sir, and have come to that conclusion. I have talked with people, and I go to Canada about four times a year and talk to the establishment there.

I listen very keenly. We do surveys in Canada. I would say that I think my judgment is, just based on not only Canadian public opinion but also Canadian articular opinion, is that they disagree with you. I think they feel our system is better than ours and feel very proud of it, just as in many areas they don't feel their system is superior to ours.

Let me say one thing about Canada is that they live in our shadow and they know that the United States, in all our TV programs. We get none of theirs so it's true, we know very little about them and they know a great deal about us.

When Canadians say that they think their system is better than ours, I think they probably know more about our system than you may imagine. So, they may have a basis for comparison here.

Mr. ROWLAND. Dr. Blendon.

Mr. BLENDON. Yes. One of the things the networks asked me, what should you do with a study like this. I said from my point of view two things. One is, network TV should start putting cameras up with patients in Canada and interviewing them. Let's get it out straight so the Americans can find out what you believe.

The second thing is, I think the Congress should name some independent panel to go up and ask some very objective questions. Do we ration here, do people have to wait hours, do people not get heart surgery, how do we keep the rural hospitals from going bankrupt, what do they do about malpractice.

What we have at the moment is a series of arguments down in the States about something where there has been a shortage of objective looks. I think it would be very, very helpful if we could get away from the ideological arguments and just say how do they pay their doctors? Do they go up or down, are people waiting in the emergency rooms.

I don't personally know the answer to that question. I have heard distinguished physicians tell me it's the finest care in the world. I have heard Dr. DeBakey on the other side. I don't know what to do. I think some objective looks, including television—I think some interviewing families and patients and doctors will give the American public a view.

But this subcommittee could be very helpful if it had its own independent look at Canada and reported back on these questions with some degree of objectivity based on a really tough look and not what we are now in, an argument, based on experience that many of us have never had on a first hand basis.

Mr. ROWLAND. I think that's a very good suggestion to do that. I am very distressed about our delivery system in this country. I think we really have to restructure our whole system, because it is not taking care and providing quality care. In my opinion, I think

that it is essential that we have adequate health care. I think that is important to the well being of our country.

I don't want us to all of a sudden move in the direction of patterning our system after a system that might not be what we really need here. I think the suggestion that we who may be in positions of responsibility go and look at other systems and really find out just how they are working would be a proper thing to do.

Mr. WAXMAN. Thank you very much, Dr. Rowland. Mr. Bruce.

Mr. BRUCE. First of all, let me thank the witnesses. Mr. Chairman, I have a statement that I would like to put into the record.

Mr. WAXMAN. Without objection, it will be included.

[Mr. Bruce's opening statement follows:]

OPENING STATEMENT OF HON. TERRY L. BRUCE

Thank you Mr. Chairman for holding this hearing. We seem to be in an unenviable situation. Physicians are reimbursed by the Federal Government at less than the cost of providing care. The beneficiaries of Federal health care programs want more benefits and are unwilling to pay for them. However, we spend an enormous sum of money, both government and private, on a system with which everyone is unhappy.

This hearing focuses on health insurance. Those with health insurance are paying now for those who do not have it through higher insurance premiums. We have told hospitals they must treat the sick and injured regardless of ability to pay. Hospitals paid $7.2 billion in 1987 providing care to the medically indigent in 1987. There is no question that this system is in need of repair.

We simply must devise a more efficient and effective system of health care in this country. Government intervention will be necessary if only to cut through the tangled web of overlapping jurisdictions, programs and priorities. I think this subcommittee must think through which health care problems are the Federal Government's responsibility—and which are not.

Mr. Chairman, I commend you for bringing together this group of witnesses and I look forward to their testimony.

Mr. BRUCE. I would like to thank the two witnesses. As an old social scientist, I don't want to criticize you for what you didn't poll on. I listened very closely to Mr. Harris, your comments about costs and how that affects peoples opinion. I would very much like to contact your later and share, if you would, some of that data on costs and satisfaction.

Mr. HARRIS. We have in the survey something on cost, contrary to what Mr. Nielson said. When we asked the people who said they couldn't get adequate care what was the reason, we deliberately didn't suggest that cost was the reason, but 58 percent of the people who said they couldn't get adequate care in the past year volunteered lack of money, insurance and couldn't afford the cost.

Cost was very much in there, right out of their mouths, Mr. Nielson. People volunteered, which is much better than suggesting it in a closed-end question.

Mr. BRUCE. I appreciate your work in this area. All of us have used polling data. I have been polling in my district for almost 20 years now, in the southeastern Illinois district. I can tell you that after 19 years in elective office, you get through the soles of your feet exactly what you have done in this survey.

I mean, I have met with my doctors and they are very dissatisfied with the program. I have met with hospitals, have had two mergers in Danville and Champaign, IL, major hospitals. I have had the closure of a hospital. I have eight hospitals that are now

not making money, running anywhere from $170,000 to $800,000 a year in deficits.

Then when I meet, as I will in the last week in March with my constituents in 21 town meetings, I will find out that every senior citizen that comes to my meeting has a complaint about the system. So, I would say that doctors, health care providers and hospitals that are receiving patients, and in particular the elderly, are dissatisfied with the system.

I think that your report has shown that. Now the question is, what to do with your data. I noticed Mr. Harris on national public radio this morning, and it was referenced in your report here, about what taxes people would support. Although you mentioned both on the radio and in your testimony that when we talk about acid rain, the homeless, toxic waste that people would support an increase in taxes, did you have a chance in that survey out this week to talk about health care and health care issues?

Mr. HARRIS. Only in certain ways. I will read you exactly what we asked. I have that right here, in front of me. If you had to choose, would you favor more government spending. This is sort of along the lines of Mr. Dannemeyer's suggestion. More government spending—these are 10 areas mentioned by President Bush's address to the Congress where he wanted to see more spending on.

Even if it means raising your taxes, or would you favor no more Federal spending and not raising taxes on this. This is the rank order: helping the homeless, 71 to 27, they are willing to raise their own taxes for that right at the head of the list. Second, stricter control of acid rain, toxic waste dumping, 68 to 30 percent, which involves this subcommittee but is also a health matter.

Third is controlling drug abuse, 67 to 31 percent. The next is child care, tax deduction of the poor, 66 to 32 percent. Then AIDS research, 63 to 34 percent. Then you got a merit school program, 46 to 42, but less than a majority would be willing to raise their taxes for that.

Then you've got basic scientific research, which shocks me but 49 to 46 percent are unwilling to raise their taxes for that. Creating enterprise zones and black ghetto areas, 50 to 40 percent not willing to raise taxes for that. Then you get SDI Star Wars, nuclear defense programs, 73 to 23 percent not willing to raise their taxes for that. The plan to bail out these failing S&L's, 76 to 18 percent not willing.

That's pretty clear cut evidence. What it is, I would add, by 73 to 24 percent, people give President Bush's highest marks for asking for a kinder and more gentle America. I think what he is getting back now is real compassion from the American people to help the least fortunate amongst us.

What you all do with that, with the leadership the President supported you on it, is I would say a major question for Republicans and Democrats have to face.

Mr. BRUCE. I appreciate your polling data. Some of us think that the SDI program is a missile health care program and would like to take the $40 billion annually that program is supposed to use and maybe talk about child health care and patient health care. I appreciate your polling data and will contact you about some more of the cost information that you have.

Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you, Mr. Bruce. Mr. Richardson.

Mr. RICHARDSON. Thank you, Mr. Chairman. Dr. Blendon and Mr. Harris, your polling seems to indicate that the American people want more coverage, they want more access. Yet, why is it that when I go home to New Mexico and hold a town meeting, everybody is up in arms about the catastrophic bill that we passed in this last Congress which gives more access, more coverage. We increase the premiums on certain citizens that probably can pay more than those who cannot.

I would like to know if your polling data examined that question. I don't suppose you had a question on that.

Mr. HARRIS. You are saying that your constituents don't like the catastrophic legislation?

Mr. RICHARDSON. No, I think every member of this body receives tons of mail saying that the catastrophic plan that we produced after the AARP and many other groups said they supported it, now when it means that they have to pay a little bit they don't like it. They want us to change it.

Mr. HARRIS. How do you sense they want to change this, so they don't have to pay you mean?

Mr. RICHARDSON. That's what I am asking you. You are the——

Mr. HARRIS. This would bear out what we are getting. Let me say this for the first time. I can go back with you over the past 25 or 30 years. We asked about national health insurance paid for by the government. We did not get majorities.

Today, you are in desperation because of cost, I think. You are beginning to get a majority forming up to say we want a system under which we don't get hit from the blind side on costs every time we go out and need medical care.

If this means, and this is a very reluctant decision on the part of people, if it means some sort of national health insurance—let me say that people love the idea of a universal health insurance for everybody which is paid for by employers, even though when we did followup questioning on that during the political campaign and said that would likely be passed on to you, they said fine we will do it.

I think the key is that people want universal health care in this country. They are shocked that some don't have it. They are horrified when they go and try to get it and it isn't accessible to them. We are very pragmatic people. We will not buy one idea, we will buy 13 different approaches if they will work. We are very pluralistic about it, we are very pragmatic.

Above all what they don't want is to suddenly say that now you have some health care that is available. Go out and try it, and then find that there is some hidden kicker to it in terms of cost or something else that they didn't know what there.

Mr. RICHARDSON. I won't pursue this. It is rather disturbing, because I know that many here worked on this legislation. While imperfect, I think it is a step in the right direction. Obviously, we need to deal with long-term health care and we need to deal with nursing home care.

I am just wondering if you are ever going to make the public happy on this issue.

Mr. HARRIS. You mean, it's paying for the poor that they don't like; is that it?

Mr. RICHARDSON. Yes.

Mr. HARRIS. Let me tell you what we find, and this is very interesting. On lifeline telephone service which is an issue, we cannot get a majority. We get like 60 percent consistently saying that I don't want to pay any of my money for that, for the poor and elderly and so on.

On health, that's an exception. People feel that health is the one area that everybody is entitled to have health care in. This is the one area of greatest compassion that we have.

Mr. RICHARDSON. Mr. Harris, looking at this in a political context, assuming that health care becomes a major issue, I know everyone probably thinks it is but what I mean by a major issue is one that will change Congressman, defeat the people, people win or lose.

At the rate we are going not dealing with health care the way we should, who are the people blaming for this? Is there a generic Congress, administration, business, hospitals? Who are taking the biggest hits right now in terms of public opinion data, polling data that you would say beware, watch out?

Mr. HARRIS. Mr. Richardson, at the risk of introducing a whole other area, I think it is a very relevant one. I attended a meeting here about 3 months ago with about 130 corporations, a closed meeting that was held and many of whom are our clients.

I was astounded when the number said we have so much unfunded liability in the health care area, especially to retired employees and business now has a major problem of having more employees supported in their health care and their retirement than there are people working for them that in the privacy in the room—and you have pressed me to say who said what, I'm sorry I don't think I should say it—I was amazed the consensus among those—these are all Fortune 500 companies.

They said you know, the greatest mistake we ever made was to not let the Government go have national health insurance. It's killing us because we now have demands upon us and we are getting blamed here because we just can't do it. We just can't swallow it and can't do it. I was amazed. That really hit me right between the eyes. That was the consensus.

Mr. WAXMAN. Thank you very much, Mr. Richardson. Dr. Blendon and Mr. Harris, we appreciate your testimony. Mr. Nielson had some additional questions and with his permission and yours, we would like to have you respond to those in writing for the record.

Mr. NIELSON. I was just going to ask for that.

Mr. WAXMAN. Thank you very much for being with us.

It is with particular pleasure to welcome the Honorable Paul Rogers before the subcommittee which he chaired with such distinction. Congressman Rogers was responsible for many laws that have benefited the citizens of this country.

He joins us now as the cochair of the National Leadership Commission on Health Care. Also representing the Commission is Uwe Reinhardt, who is the James Madison Professor of Economics and

Public Affairs of Princeton University and was a member of the Commission.

Unfortunately, the Honorable Robert Ray, who was the Commission's cochair, is not able to be with us this morning. With Congressman Rogers and Professor Reinhardt is Mr. Henry Simmons, the President of the Commission.

I want to note that there were four dissenting opinions registered when the Commission's report was filed. We invited the dissenters, but they were not able to attend.

Mr. Rogers, we are pleased to have you with us. Let me indicate that your prepared statements will be in the record in full. We would like to ask you, if you would, to give us no more than 5 minutes for your oral presentation.

STATEMENTS OF PAUL G. ROGERS, COCHAIRMAN, NATIONAL LEADERSHIP COMMISSION ON HEALTH CARE, ACCOMPANIED BY HENRY SIMMONS, PRESIDENT; AND UWE E. REINHARDT, FORMER MEMBER

Mr. ROGERS. Thank you very much, Mr. Chairman and members of the subcommittee. It is a pleasure to be back with my colleagues on the National Leadership Commission on Health Care. It is hard to believe, Mr. Chairman, it's been 10 years since I had the honor of sitting in the chair which you grace so well. It goes fast.

I think the topic you have chosen, health insurance and reforms in health care is a very timely subject. Certainly, it is important for every family in America. I think it is well that you have begun these hearings.

The National Leadership Commission on Health Care is a bipartisan group of citizens who came together to look at the health care system and see what they think should be done to improve it. First of all, we started this in 1986, about 2½ years ago. We had many, many witnesses and had participation from all over the country. It really was a blue ribbon panel, and have spent the last year trying to come up with some suggestions.

They identified, of course, three major problems. First, the lack of access that we have been talking about this morning, the lack of access for millions, 37 million, soaring costs for health care system, and uncertainties over the quality of health care.

After a careful examination of these problems, the Commission came to the conclusion that they are so interrelated that to try to fix one up without addressing the other two does not make good sense. Really, all three should be addressed and we should have a systemic approach not a piece-by-piece.

A good example of that is, you know, when we tried to control hospital costs. We controlled through the DRG inpatient care. It did do some good, and it has held that increase down. But what happened was, we had the ballooning of outpatient care and now the health costs are still going up far above the rate of general inflation.

As all of us know, the cost now is $600 billion. In 1995 it will be $1 trillion and $1½ trillion by the year 2000, which isn't far away. Unless we do something when we talk about costs and taxes, we haven't even looked at the problem.

Just think of what is going to happen when we have to produce $1½ trillion in the year 2000. Well, the cruel paradox with that, with all these billions we are spending, we are still not covering all of these people, the 37 million. We have had examples here today. Of this 37 million, 11 million are children that are not getting proper coverage.

We felt something was really needed and we need a new approach, and we don't think any single group can do it. We don't think the government by itself can do it, providers by themselves can't, doctors and nurses can't, labor can't and business can't.

What we need is to work together and have a new private sector government approach on this, and that's what we call for in this Commission report for a new public/private partnership in the American tradition. Not in the Canadian, not in the English, but in the American tradition. That's what this Commission proposes.

Now let me just say, and then I am going to conclude. The Commission decided to build on the solid parts of our existing system and to the maximum extent, be sensitive to American preferences including pluralism, freedom of choice. We rejected a centrally controlled governmental solution because we felt that would not be acceptable to the American people.

As I said, we opt for the new public/private partnership with extensive private sector involvement so we can retain as much flexibility as possible, encourage and strengthen market forces. At the same time, we know there must be a Government participation.

Finally, the solution that we propose points the way to a series of integrated changes in the three problem areas. Our proposal does provide universal access to a basic level of health services, which will be explained by Dr. Reinhardt. It helps to control escalating costs through the use of economic leverage in the purchase of care, economic incentives including cost sharing and the elimination of unnecessary care.

It asks for greatly increased research on the appropriateness of care, leading to the development of practiced guidelines that will result in less inappropriate care.

Thus, the Commission believes that reducing unnecessary procedures will both help to contain costs and improve the quality of health care. In addition, our recommendations for malpractice reforms will reinforce the efforts to contain costs and improve quality.

I would like to turn the microphone over now to Dr. Reinhardt, who is one of the most distinguished economists in the country in health, recognized all over the world and really is knowledgeable in this subject.

He will discuss with you quickly, access and financing.

[The prepared statement of Mr. Rogers follows:]

Testimony of the

NATIONAL LEADERSHIP COMMISSION ON HEALTH CARE

Mr. Chairman, Members of the Committee: It is a privilege to be invited to testify before the Subcommittee on Health and the Environment. The topic you have chosen, health insurance coverage and proposals for reform, is both important to every family in the country and timely to every policymaker, as the number of proposals being presented today demonstrates. The National Leadership Commission on Health Care which we represent believes, as you do, that it is time for us to reassess the strengths and weaknesses of our health care system and propose those basic changes which will make America a healthier society as we face the challenges ahead in the nineties and the twenty-first century.

The Commission was formed in 1986 by a group of concerned citizens to address the problems in our health care system. The Commission brought together leaders drawn from all the major sectors in health care: providers, business, labor, and public policy. These are the very groups which must come to consensus about solutions to the serious problems facing the country in health care. This blue-ribbon panel identified three problems: lack of access for millions of Americans, soaring costs, and uncertainties over the quality of care. After a careful examination of these problems, the members of the Commission became convinced that these three problems were so interrelated that it no longer made sense to try to solve each of them in isolation.

In fact, the Commissioners found that the piecemeal solutions proposed in the past had only shifted the burden of the problems in health care from one sector to another, not solved them. For example, through the work of your committee and the efforts of

ProPAC and HCFA, we have been able to control the rate of increase of inpatient hospital costs. But hospital costs for outpatient care are increasing at three times the rate of inpatient care, so the bottom line for overall health expenditures continues to rise faster than the rate of general inflation. Two years ago, we spent $500 billion on health care; this year the number will be over $600 billion. It is expected to hit one trillion dollars by 1995 and $1.5 trillion by the year 2000, when health expenditures will be 15 percent of our gross national product or $5,551 for every man, woman, and child in America.

The cruel paradox is that while we are spending billions more every year to provide health care, we are failing to provide basic health services to millions of Americans. Today, 37 million Americans are uninsured, a significant number are underinsured, and both groups are often relegated to inadequate care. Over eleven million of the uninsured are children, the future of our society. The Commission believes that these people should all have access to a basic level of health care. This is a social good that we believe Americans will support.

However, we cannot achieve needed change without a new strategy. None of the existing strategies seems likely to succeed. Cost shifting will only aggravate our problem. We need a new approach. But no single group -- business, labor, providers, insurers, or government -- can solve this problem alone. Government and the private sector must, together, develop a common vision of the future and a long-term strategy to use there. We call for a new public-private partnership.

For the past year, our Commission has been developing a long-term solution to a system undermined by three interrelated problems. The continued existence of these problems presents a clear and compelling case for change. Recognizing the failure of twenty years of patchwork attempts, we concluded that nothing short of a comprehensive plan, which

includes solutions to the cost, quality, and access problems, and malpractice reform as well as reforms in medical practice and delivery, is likely to achieve the goals of cost control, universal access and quality that everyone, including health professionals, wants.

We decided to build on the solid parts of the existing system and to the maximum extent possible be sensitive to American preferences, including pluralism and freedom of choice. We rejected a centrally controlled governmental solution because we felt that would be unacceptable to the American people. We opted instead for a new public/private partnership with extensive private sector involvement so that we could retain as much flexibility as possible, encourage innovation, and strengthen market forces. At the same time, we understand that no market in health care can work without some regulatory oversight.

Recognizing that if you don't know where you are going, any road will get you there, we first developed a vision of an ideal and just health care system toward which this nation should strive. Our report begins with this vision and also a recognition of some of the ethical issues with which our nation must grapple as it decides on a new national health policy.

We decided that in a civilized society, all citizens should have access to a basic level of health services. Our report contains seven fundamental principles which we feel should guide a policy to bring the uninsured into a comprehensive health insurance system. This includes the principle of a basic benefits guarantee which we feel should be uniform nationally and established under Federal enabling legislation. This principle owns up to the widely shared notion that there ought to be a floor of health care beneath which no American would be permitted to sink, and, moreover, that citizens in one state should take an interest in and feel responsible for what is done and not done for suffering fellow Americans in another state. A health care system that exposes the health care of

American infants in Texas or Louisiana to the vagaries of oil price policies hammered out in the Middle East is judged by our Commission to be fundamentally flawed.

But the Commission also felt strongly that its plan should provide universal access only to a system which also held cost increases under control and provided an improved quality of care. The members of the Commission were troubled by the persistent reports and an increasing number of studies reporting on the uncertainties in the appropriateness and effectiveness of care being delivered. It has become clear that these problems are not isolated in a few specialties but are generic to the health care system. The system has failed to develop an adequate body of information to enable all parties -- doctors, hospitals, insurance companies, payers, and patients -- to assess the quality and appropriateness of health care.

Therefore, the Commission is calling for a comprehensive solution in three parts to a troubled health care system undermined by three very serious problems. We are concerned, because the problems are serious, systemic, and, without a solution, will grow worse. But we are hopeful, because all the major participants in the system are now anxious to become involved in a solution that works.

The solution proposed by the Commission points the way to a series of interrelated changes in the three problem areas. Our proposal provides universal access to a basic level of health services; it controls escalating costs through the use of economic leverage in the purchase of care, economic incentives including cost sharing, and the elimination of unnecessary care; and it asks for greatly increased research on the appropriateness of care leading to the development of practice guidelines that will result in less inappropriate care. Thus the Commission believes that reducing unnecessary procedures will both contain costs and improve the quality of health care. In addition, our recom-

mendations for malpractice reform will reinforce these efforts to contain costs and improve quality.

The Commission's plan builds on the pluralism in the American health care system and proposes a new public/private partnership. Under our proposal, all Americans would be responsible for having health insurance for a package of basic services. There are several ways in which such coverage could be secured, including employment-based coverage, personal payments, or participation in our Universal Access, or UNAC, program. The UNAC program would provide access to a nationally determined package of basic health services, to be set forth in enabling federal legislation. In addition to extending coverage to the 37 million Americans now without it, the plan would cover those who are now underinsured. The Commission anticipates that about 67.9 million people will become covered under the UNAC program. If all employers choose to provide insurance rather than pay the fee, the number in the program could be as small as 42.9 million.

This program would spread the cost of paying for universal access across all Americans over 150 percent of the poverty level and across all employers, thus making the health care premium between one-half and two-thirds of one percent of incomes up to the Social Security maximum. This premium would also pay for a greatly increased research program to enable us to develop guidelines for the practice of medicine which will help the providers of that care, the payers, and the patients as well to make better-informed decisions about when it is appropriate and when it is inappropriate to provide a procedure or treatment.

The Commission used the system that is already in place as a building block for its UNAC program. Therefore, the Commission's plan provides financial incentives to encourage employers to extend coverage to all employees. The plan also would use existing state

agencies where possible to implement the proposal, administering the UNAC program and acting as prudent purchasers in negotiating fair compensation for health care for the uninsured. By using existing organizations, we avoid adding another layer of bureaucracy to the system and at the same time we permit the states to add to the basic level of care if they so choose.

A hallmark of this system is individual responsibility, and the Commission is in favor of making consumers aware of the cost of their health care through cost-sharing for those who can afford it. Therefore, the Commission recommends the state agencies use a flexible deductible and copayment system. The Commission also supports the increased cost sharing that has developed in the private sector over the last few years and encourages additional progress in this regard.

But the Commission's approach to cost control goes beyond these provisions. It would remove cross-subsidies and make explicit the cost of care for all. It would level the playing field for American industry. It is also inextricably linked to the Commission's proposal for improving the quality and appropriateness of health care. Some and quite possibly all of the cost of providing universal access could be made up in savings resulting from improved quality control. The Commission's strategy is designed to improve both the value of care and the efficiency of the systems that provide care. A marketplace approach by definition, the Commission's proposal would greatly increase information available to providers and patients on the quality and appropriateness of health care.

The Commission believes that health care professionals, patients, and payers need several types of knowledge. They need to know which tests and procedures are appropriate for an individual situation. When guidelines exist for particular conditions or treatments, they need to examine the scientific basis of those guidelines to determine its adequacy.

They also need more information about which medical practices are truly effective and which are not. And they need better ways to measure what happens when care is provided and how it can be more effective. This can only occur within a general understanding that each patient presents a unique set of problems.

Improving information on quality and appropriateness will have far-reaching effects. In addition to reducing the level of uncertainty, which in turn reduces unnecessary and inappropriate care, improvements in quality and appropriateness information should also help stem the tide of increasing health care costs, increase efficiency, improve the doctor-patient relationship, and reduce defensive medicine and malpractice suits. Fortunately, there is solid evidence that health care providers will use relevant, well-presented information to improve the quality and appropriateness of their care. Government agencies and private organizations are already pursuing this effort. Much more needs to be done. We need to assure a consistent, substantial amount of research funding so that practice guidelines can be developed and continually updated to assure continuous improvement of the quality of health care in an era when new technology is pouring new procedures into the system without adequate evaluation of their appropriateness and without comparison to established technologies.

Our National Quality Improvement Initiative would fund such work and would involve periodic collective priority setting, coordination, and progress evaluation. Funding would be part of everyone's health premium and would amount to about one one-hundredth of one percent of incomes up to the Social Security level. It is clear that an investment of up to $500 million a year will yield savings in the billions every year from the elimination of unnecessary care and inappropriate procedures.

A reform of the malpractice situation will go hand-in-hand with this initiative, under the Commission's plan. It is clear that malpractice litigation has driven up the cost of medi-

cal care overall and, in some specialties, at a dramatic rate. High insurance rates are passed on in increased fees to patients. The fear of malpractice suits encourages defensive medicine, in which providers perform additional procedures, especially diagnostic ones, principally to protest themselves against law suits. Such procedures increase both the cost of care and sometimes health risks to patients. The current system of malpractice litigation also corrodes the patient-physician relationship.

We have been encouraged by the breadth of interest in reform both within the medical profession and outside it. Some promising proposals have been adopted experimentally on a state or local basis, and we strongly support continued exploration of potential solutions and the adoption of the most promising reforms at the national level. Such proposals include instituting strict criteria for expert witnesses in malpractice suits, strengthening standards of negligence, limiting punitive damages and contingency fees, and encouraging mediatioin and arbitration as alternatives to lawsuits for resolving disputes. If change does not occur rapidly at the state level, the Commission encourages the Congress to consider legislation such as a no-fault system which would compensate regardless of whether there has been malpractice. This is an area where Congress has already acted, as with vaccine-related injuries, removing these troublesome cases from the tort system. Whatever precise reforms are adopted, we are convinced that the problem of malpractice must be addressed so that it does not impede solutions of the more critical issues confronting the health care system.

The national health crisis is real. The solutions proposed by the National Leadership Commission call for systemic change to achieve three principal goals: an adequate level of care for all Americans, a climate that fosters careful and effective cost control, and significant, continual improvement in the quality of care. We believe that our nation cannot call itself healthy if as many as one out of four Americans may lack adequate access to health care. A widely shared responsibility for providing this care will never become an expensive burden for anyone if we incorporate in this new system strong elements of cost control and quality improvement.

We are hopeful that a systemic solution to the serious problems in the health care system is now possible. Much has happened in the two-and-a-half short years of the life of the Commission that indicates to us that all the parties involved in analyzing, delivering, paying for, and benefiting from health care in this country are anxious to become involved in a solution that works. We hope that our strategies will suggest a way.

STATEMENT OF UWE E. REINHARDT

Mr. REINHARDT. Thank you very much. I am sure Congressman Rogers says that about every economist.

Mr. ROGERS. I don't know any other good economists like you.

Mr. REINHARDT. Thank you, Mr. Chairman, for inviting me to speak before this subcommittee. It is a privilege. I think I had the privilege of testifying before, but that time I wore the hat of the physician payment review commission. One of these days I will speak on my own behalf.

It was a fascinating learning experience and also an exhilarating experience to participate in the group of private distinguished Americans trying to wrestle with the problem before us in a way that was not going to make everyone perfectly happy but was the traditional American compromise. That is the program that I would like to present.

This program is based on a number of principles. We actually articulated seven, but there are four that are very important. The first one is the principle of access. That is that in the civilized society, no member of that society when they are sick should have financial barriers between them and needed care, as there are now in this country. That was fundamental.

Second, in the United States as in other countries, no provider of health services should be required to give health care without compensation. Note that Congressman Rowland mentioned the oath physicians swear. I don't know which one it would be, but I believe it would be the hippocratic oath says nothing about charity care at all. There is actually no such commitment.

It is presumed by everyone. The hippocratic oath, I do not believe, contains a line on charity care. No other country requires their doctors, nurses or hospitals to work for nothing, nor should we.

The third principle is that financing health care should be a shared responsibility. There are rich and poor people in this country, and income and health are not equally distributed. Those who are well-to-do and healthy should subsidize those who are sick and poor.

Finally, that health care for the minimum benefits to which an American should be entitled should be a national definition and not a State and local definition. In plain english, I in New Jersey should care what is or is not done for a sick infant in Texas and vice versa. That is the very basic minimum of the idea of national.

Those were the principles we started with. Out of these principles, we then fashioned over many, many hard argued sessions the following scheme. There should be a federally legislated fail-safe system to which every American would belong unless they have private health insurance. If you don't have an adequate private health insurance coverage, you are in the fail-safe system. That would obey the principle of access and the principle that physicians and hospitals should be compensated.

There would be no more uncompensated care, no one could fall between the cracks, because there aren't any cracks. That is for eligibility.

Benefits, the basic package was not defined by us. There are many around, I think the health policy agenda for the American people had defined a benefit package that I personally think is a very fine package. We left that open for the political process to define, but it would be a basic package that Americans could be proud of as a Nation.

The administration of this system which we call the universal access, would not be at the Federal level. It would be at the State level within the Federal guidelines set forth in this fail-safe system. There would probably have to be in every State, a newly established State board charged with the task of procuring health care for those Americans who are in this fail-safe UNAC system.

They wouldn't have to negotiate rates with doctors and hospitals and other providers or take them on competitive bids. We would encourage them to use managed care systems such as maintenance organizations or preferred provider systems, but it would be left up to the State. The idea here is to allow flexibility and the innovation for which the American health system can, in fact, take credit.

Whatever you say about the American system, it is an innovative system. The cost of this kind of scheme for the 37 million uninsured, the current rates you are talking about $1,100 to $1,200 for fully insured Americans under 65. Uninsured Americans now get about 60 percent of that in the way of health care.

So basically, the extra health care we would have to pay for as a Nation is only the extra 40 percent, which we estimated or it was done for us by ICF, $24 billion. I think personally, that's an upward estimate. The additional national health expenditures, in my view, would be less if we do it at all reasonably well. We didn't want to fool people so there is an estimate of $24 billion additional on top of the $550 billion we spent last year in any event.

Although, if we were smart in other areas, just in paper what we waste in paperwork, it is more than twice that amount. The financing would be shared. There are many ways you could do this. Our Commission mainly spent time on defining the framework of access.

You could use a mandated benefits scheme, of course. You could use the kind I had proposed in the Wall Street Journal, which is basically an income tax scheme. The Commission decided to have a more pluralistic financing scheme. We would not mandate employers to give health insurance, as some legislation including your own provides.

We would, however, provide incentives in the old fashioned American ways. That is, we would make it so that an employer would be financially encouraged to provide insurance. That would be done by telling an employer, if your employees do not have health insurance you must pay a premium based on payroll equal, we estimate just for an illustration, equal to 9.68 percent of payroll and the employee would have to pay roughly 2 percent of payroll.

That would pay for those employed workers whose employer does not give health insurance. But the employer could pay that and not have to provide the health insurance as such, and get into the business of managing care.

Individuals above 150 percent of the poverty level would pay the 2 percent of their payroll into this pool. There probably would then

be a shortfall in the pool of what this would really cost. Therefore, we would ask every American above 150 percent of poverty and corporations to pay a so-called very small tax for individuals—I think it would be something of less than 6 percent of income. That would be rich and middle class contributing to a pool for the poor.

We call it a Y tax, to be perfectly neutral. I personally would call it the membership fee in the club of civilized nations. That's what that is. Or, a down payment of the Judea Christian ethics and I would put other ethics in there too. I am mindful of the Ayatollah.

This scheme is more fully articulated. There would be cost sharing, there would be deductibles within reasons. I believe this scheme, of all the schemes tha/t are before us, is very competitive because it builds on the American tradition. It is well known that I have great admiration for the Canadian system. I am not sure that we could legislate this in the United States.

We could make certainly, if it is feasible in the next few years, implement this kind of scheme. I must say that there were dissenting letters. One of them I responded to. If our chairman doesn't object, I would be happy to share that dissent with you.

There was an implied response. The United States Steel Corporation distributed, in fact, the write up of the Canadian scheme. I infer from that—I can't be sure, but I infer—that big American business is becoming enamored with the Canadian scheme.

Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you very much. There is a certain amount of irony in the changing attitudes about this problem. What I think we have heard this morning is that Americans are dissatisfied with their health care system. I want to commend the Commission for the work you've done in giving us some other alternatives in addressing the major issues of access, cost containment, and making sure that the health care system accomplishes what people would want.

Mr. SIMMONS. Mr. Chairman, there are two other critical points that we needed to make. One, the Commission universally has said that this Nation should have universal access. There were two critical caveats. It was that it shouldn't be done unless there is an effective cost containment mechanism built into it. We certainly don't want to provide access to the system with the waste, the inefficiency, the poor quality, unnecessary care which exists.

To do that would be a national tragedy. Therefore, what we are advocating is a solution that deals with all three issues at the same time. If you then say what the cost of this program is, it could possibly be at no cost, because the Commission truly believes that the waste in the system is so substantial and could be addressed if we had the will to do it that we could, in fact, have a system of universal access, better quality with reasonable costs with these comprehensive solutions that we propose.

I guess our final message to your subcommittee, Mr. Chairman, is that whatever we do as a Nation we do it as a comprehensive thing so that we don't do the same mistake of the past of merely compounding our problem.

Mr. ROGERS. Mr. Chairman, if I might comment on that. The Rand Corporation has already estimated that if we can improve the quality, effectiveness and appropriateness of care, they estimate

that as a $50 billion savings. That would more than pay for covering the 37 million who are not covered.

Mr. SIMMONS. In just the small part of the care, of course. In today's Washington Post, you probably saw a coronary angioplasty balloon angioplasty. Now a study in the New England Journal just published in the last few days suggests that a very substantial part of those unnecessary.

That has already been widely accepted, introduced in this country at a cost of probably $1 billion. What we are proposing is a system that would not allow that to continue to happen. Whatever does come to the American people is established as effective, is worth paying for. Then, let's provide access to it.

That gap in our present system is one of the key elements of our proposal which must be fixed.

Mr. WAXMAN. I think you certainly hit on the right points that we need to cover as we look at any possibility of moving to a broader health care system. There are so many questions that I would like to ask of you in terms of the details of how all this would work.

I don't think it would be appropriate to get into that now. We want to study this report carefully. I want to commend you on the work you have done in presenting this report to us. As we start looking at legislative ideas, I know that we will want to visit with you again.

Let me call on my colleagues to see if they have any questions. Mr. Nielson.

Mr. NIELSON. Yes. Dr. Reinhardt, I was quite impressed with your point of view that it should be a cooperative thing building on our present system. That was the point I was trying to get across unsuccessfully to Mr. Harris, that we have a lot of good and don't throw all the good stuff out.

I would think that a partnership of the private, the employer and the insurance company and the government, all four participating, would have a long ways to solving this.

A few years ago we had a bill on health insurance for the unemployed based on people who lost their jobs because of trade and other problems. We put the whole burden on the Federal Government. We didn't require the insurance company to keep them in the system and allow them to have group benefits a little longer. We didn't build in a protection by the employer and the employee to have an automatic extender. We didn't do some of the obvious things that I think could have helped at that time so I am glad to see you mention that.

May I ask two questions. When you say no one should be denied access to health care, are you suggesting that there should be some responsibility on the individual employee? For example, if I work for a company and the company is big enough to make health insurance available to me, if I as an employee don't want it and refuse to pay my part of it, are you still going to pick me up or do you think there should be some responsibility on the part of the employee as well?

Mr. REINHARDT. The Commission had the view that it is actually unfair for an individual to self-insure unless they can literally cover their health expenditures should they be hit by a truck. In a

society that obeys the social ethic that we do, when somebody is bleeding or very sick, we feel compelled to help them.

Therefore, to allow people simply to opt out and take chances, they are really taking chances with our wallet. We would say it is your duty to be insured. If you can pay for it out of your own resources, then you should substantially contribute to that. If you cannot, this society will stretch out its hand to you.

That's really the philosophy of this.

Mr. NIELSON. I certainly approve of that, and I'm glad to see it. Will we have a copy of this report so that we can study it in detail?

Mr. ROGERS. Yes. It has been furnished to staff, but we will be able to furnish details to you.

Mr. NIELSON. I don't want to appear entirely negative to the panel on this particular subject. We build on the strengths we have, make as many cost containment things we can, but I also think that we need to look at the individual responsibility as well as the employer and as well as the insurance company.

I think the insurance companies could be a little more willing to allow people to stay in the group plan. These ladies who talked to us earlier this morning indicated that as soon as they lost their job they were dropped from their insurance plan with no extension at all, not even a transition until the next job. I think that ought to be legislated as necessary.

I thank the Chairman, and thank you for your presentation.

Mr. WAXMAN. Thank you, Mr. Nielson. Further questions, Mr. Scheuer?

Mr. SCHEUER. Thank you, Mr. Chairman. Dr. Reinhardt, when you testified before our subcommittee last year, you did testify on your own behalf.

Mr. REINHARDT. Yes, I did, indeed.

Mr. SCHEUER. You expressed the hope that after testifying on behalf of these organizations that one day soon you would have the opportunity to testify on your own behalf again.

Mr. REINHARDT. I was teasing.

Mr. SCHEUER. I am going to give you that opportunity now. I am going to ask you to sever your mental connection with the Commission and testify for moment or two on your own behalf, OK?

Mr. REINHARDT. OK.

Mr. SCHEUER. As I recall your testimony last year, you testified that there was endemic waste in the life and breath of our system. Without putting words in your mouth, my recollection is that a good deal of this waste was a result of excessive, irrational pluralism, if you will.

Is that a reasonably fair paraphrase?

Mr. REINHARDT. Actually, the testimony—I just looked at it the other day again. You may recall, you had to give me immunity to articulate what I really thought about it. I have, in the testimony I think, the All American Health Care bill.

The bill reads as follows: for services rendered, $100; pluralism surcharge, $20; total bill, $120.

Mr. SCHEUER. Dr. Reinhardt, it doesn't take a mathematical wizard to figure out that there's a 20 percent waste factor there. It was that that I referred to.

Mr. REINHARDT. That was the thing. And then the question when you bring this up one is told, and don't forget that I grew up under the West German system of national health insurance and the Canadian national health insurance system. I think those were good experiences for me as then, a low income person.

When you ask Americans to say but ah, we have a pluralistic system. I raise the question, I don't know what that is. It must be a wondrous thing, because you are paying so much for it. I personally would not pay it, if I could avoid it.

Mr. SCHEUER. Do you mind my finetuning my question? We want at all costs to preserve freedom of choice. If that's what you mean by pluralism, I think the American public is willing to pay through the nose to preserve freedom of choice. If that's not what you mean by pluralism and if that 20 percent waste factor is something else other than freedom of choice, then I think we need a national debate as to whether the American people want to pay for that kind of pluralism.

Remember, we have other national needs. We have the need to put hundreds of thousands of kids as risk into a head start program to provide them daycare. We have the need to produce more post-doctoral fellowships for the National Science Foundation. We have many national needs that are competitive with health care.

We don't want to waste money on health care. I think we are willing to pay, as I said before, to preserve freedom of choice. When you talk about pluralism, that's a lovely word. Everybody likes pluralism.

What does it actually mean in the Queen's English. Is this waste, is this duplication? What is this pluralism that we are paying a 20 percent tag for?

Mr. REINHARDT. I am glad that you ask that question. The freedom of choice exists in Canada, certainly as much as here, and in West Germany, even more so than here. My mother in West Germany gets health benefits that would make any American aged jealous what is all paid for her, including every 2 years vacations in the Alps. All that is paid for.

Mr. SCHEUER. I want to join.

Mr. REINHARDT. The pluralism that I was talking about was not freedom of choice but rather the following. In Germany and in Canada, money flows into the health care system through a few big types. The people at the valve of those types have market power and can cut deals with providers with respect to fees, with respect to what capacity there is, how many empty beds they are willing to pay for and so on.

Our system is one where the money flows from society to the providers through 1,000 and more little pipes, each of which is much too small to make any difference. The guy with the valve can turn it off and the rest of the delivery system won't even notice that.

This pluralism, others would call it divide and conquer—whichever way you wish to style it, is carefully designed to maximize the transfer of money from society through the provider system. That has some good and some bad.

It has some good in the sense that we are leading in technology because we are smart as a system with money. We are at the cut-

ting edge of medical innovation. It is bad in the sense that you will waste with such a system, enormous amounts of money and $50 billion or so probably on paper alone.

We process more paper per medical transaction than any other society on earth, I am quite convinced of that. All of this has to be paid for. What I was asking is when you concentrate the pipes, there is a danger that somebody draws on the valve too much and you starve the hospitals.

Americans tell me, we don't want to ever face this danger of someone making a mistake in the valve. Therefore, we want pluralism. That's how I understood that.

Mr. WAXMAN. Thank you, Mr. Scheuer. Dr. Rowland.

Mr. SCHEUER. Mr. Chairman, may I ask unanimous consent to submit some questions?

Mr. WAXMAN. Without objection, all members will have the opportunity if they wish, to submit questions to this panel. We would request that they respond in writing.

Mr. ROWLAND. Thank you, Mr. Chairman. Earlier, Dr. Reinhardt, I had mentioned that a physician would violate their oath if they refused to treat a patient. I believe you took exception to my remark. Let me read you from the Hippocratic oath.

I will prescribe regime for the good of my patients according to my ability and my judgment, never to do anyone any harm. At every house where I come I will enter only for the good of my patient, keeping myself far from intentional ill doing.

I submit that if you turn a person away because they are not able to pay, that is intentional ill doing on the part of a physician and a violation of that oath. Having defended myself on my statement, let me proceed to something else.

I commend all of you for what you are doing in trying to restructure our health care delivery system, because as you heard me say earlier, I think that it really needs restructuring. I think that if it is not restructured that we will eventually find ourselves in a total system of national health service patterned after the British system shortly after World War II.

As I understand it now, they are trying at least to some extent, to back out of that system because they find it is too burdensome and is really not achieving what they thought it would achieve.

I was interested in your statement that you very much admire the Canadian system. I had some information earlier that I had read about the lines that are now building of people not getting to the care that they should get as early as they should and that diagnostic techniques, state-of-the-art are not available.

Is this not true? Would you comment on that? Is this system beginning to feel the affects of being supported totally by the Government?

Mr. REINHARDT. As Dr. Blendon says, that evidence seems to be largely anecdotal. It was at the American Hospital meeting that was held in Toronto a few years ago. I asked some Canadian hospital executives, do you feel that way. Do you feel technically inferior to Americans. They were very upset at the very notion that we would think that way.

If they err on the capacity, they might err little on the downside. We will usually put more lithotriptors into a city by a factor of two

than we need and more MRI machines. They might to hit it exactly and occasionally miss on the downside.

Years ago in the late 1970's, I was part of a team that looked at Quebec and the United States. We found wait times to an appointment with a physician and wait time in the office, I believe they were identical to Quebec and the United States. I wouldn't swear to it, but that's the only objective information to which I am aware.

However, this is now begun to be studied. There is a study that was in health affairs that showed Canadians certainly get as many hospital days and as many admissions as Americans do, but they are somehow for reasons that researchers could not explain, spend a lot less in doing so. They are progressing now towards looking at heart surgery. The paper isn't out yet but it will be out. Dr. Newhouse at Harvard is working on that.

As I understand it that paper again shows Canadians get as much heart surgery as Americans, but somehow they do it much more cheaply. I am talking something like 50 percent less costly. That kind of research is only now beginning.

The stories that you read in the Wall Street Journal, Michael Walker had a piece on how Canadians cue up. There was not a single study that he could cite, it was all hearsay. Unfortunately, that's where we are.

Mr. NIELSON. Would the gentleman yield?

Mr. ROWLAND. Yes, I will yield.

Mr. NIELSON. The Roper Poll asked the question number 11, why medical care was not obtained. What was the main reason you did not get the medical help needed. And, 47 percent of Canadians said they could not get an appointment, which would tend to give credence to what you said in those lines. Forty-seven percent said they could not get an appointment, as the main reason they didn't get proper medical care.

So, there is more than anecdotal evidence then to that.

Mr. REINHARDT. That question would be something that I would——

Mr. SIMMONS. Mr. Nielson, I think you have to balance that with that other part of the poll which showed that very few Canadians were ever denied access to care or ever were unable to get care. I am not sure that you can directly extrapolate from that, that it is in any way superior.

In fact, Dr. Rowland, the case that a fair number of researchers would now begin to make as we begin to study how much appropriate care is being rendered here, maybe it would be a blessing not to be able to get into the system too fast many times because then you are not exposed to some of these things that you shouldn't have been exposed to in the first place.

We heard enough testimony on that, that I think you can't just dismiss that offhand.

Mr. ROWLAND. Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you, Dr. Rowland. Mr. Bruce.

Mr. BRUCE. Dr. Simmons and the panel members, I appreciate your work. My question is on your program. How do we inject responsibility into a national system, patient responsibility not to abuse the system.

I am particularly tying in what Mr. Harris said in his testimony, and there was additional information that he provided about the expectation of American patients as opposed to Canadian and United Kingdom patients about our expectations on a chart are very much higher.

How do we inject responsibility into the system?

Mr. ROGERS. I think one thing we would do is, first of all, suggest a good bit of research be done and then education. Right now, we have a feeling when we go to the doctor that if we go through an operation we want a perfect outcome. This has to be changed some, because it doesn't always happen that way as good as medicine is.

We think if we will begin to do a lot of this research on clinical procedures which basically have not been researched. We do drugs, we prove drugs safe and effective before they go on the market. Procedures are not done that way.

Now we think that should be done, and should be an ongoing process so that the public is given the information. The buyers of that and the doctors themselves, and it will help the doctors.

Mr. BRUCE. I am not talking so much about sophisticated procedures, although that's my next question. I am talking about the use of the system. In Illinois, Medicaid is a problem, regarding the provision for eyeglasses. We have mothers who will lose eight pairs of eyeglasses a year. How do we inject into that system, responsibility that you only get one pair of eyeglasses or you can't take a child to an emergency room for eveything.

I used to be chairman of a State employees group plan, the largest one in the United States. We told well-educated State employees that they no longer could take their children rooms and bop us for a $120 emergency room visit for sniffles. It caused a lot of ripples among 135,000 State employees.

How do you train people? We just said that we won't pay it, and they got trained real quick on that system because they quit taking their children to the emergency room for sniffles. How do you do that in this system?

Mr. ROGERS. I would think that's what you have to do in some instances, where there is sniffles and say this is not a place where we can take care of that situation. You will have to go see the nurse or whatever.

It is going to be an education process. Education and work. It takes time. It took us a long time on smoking, but it is becoming effective.

Mr. SIMMONS. Mr. Bruce, one of the things that the Commission really felt strongly about was that everybody has to take some responsibility for both the payment of their care and for their health. When you have a chance to read our proposal, you will find that we have a very strong cost-sharing component in it.

No one is freed from that, even the least able to pay. We are recommending that some payment be made at the point of service, so that this is not seen as a free service which is not in anyone's interest. You point out a very difficult problem.

Mr. BRUCE. The largest medical program we have is the 171 VA hospitals, one of which is located in my district of Illinois. We have that kind of program. Let me tell you that when we raised the co-

payments $2 for every prescription drug that a Veteran gets, I got all kinds of hell about it.

We have a copayment system now when they do outpatient care and caught all kinds of hell about it, because they didn't want to pay anything. The idea with this was a free system for Veterans. How do you get over that?

I know it is public education, but you start the program and then I know that this system, as far as I know, we are still going to elect legislators here. When you get 500,000 people saying I don't like the system where when I get a prescription I am going to have to pay $10. You say by golly as your Congressman, I am going to go to Washington and correct that. You can get your medication free.

Mr. ROGERS. Yes. Of course, that's always a problem with representative government. As we all know, they don't like to have taxes raised at all but you raised my taxes. Sometimes you have to bite the bullet. This is going to be a long-range plan. It is not going to bring solutions overnight.

I think Dr. Reinhardt wanted to comment on something.

Mr. REINHARDT. I just wanted to say on the Medicaid. There's obviously potential for abuse, but I recently received from the Congressional Research Service a marvelous little book on Medicaid, a resource book which I recommend to anyone who wants to know about the program.

I was surprised when I studied it, that the average cost for a Medicaid enrolled is not really out of line with what is spent on Americans who are not on Medicaid who are insured by business. So, overall it is actually a pretty efficient program, one has to say.

Mr. SIMMONS. Mr. Bruce, maybe one of the answers to your question, how do we change that, in part it is part of what this hearing is about. It is an educational process. One of the things that we hope will come as a result of our report is that people will begin to understand if we don't make these hard choices—I mean, it is absolutely certain that if we don't change what we are doing already highest costs in the world will double in 6 years and triple in 12.

Medicare, in only 11 years, will be larger than either the Defense budget or Social Security and on a much faster rising trajectory. We can't continue that. That is going to take some very painful decisions. One of the things we hope our report will do is to begin to educate everybody in this country that there are no easy answers here. We really do have some painful decisions.

If we don't make them, everyone is going to be compromised. No one can escape the bad effects of failing to deal with this issue, including the Nation's economy.

Mr. BRUCE. My only concern is that it seems to me that the President of the United States has been listening to the song, Don't Worry, Be Happy. We have had that for 8 years, and I'm not sure that anyone wants to bite the bullet.

I go out and talk about this in my district and I got to tell you that you see a lot of sad faces when you talk about the procedures and medical ethics and ability to keep people alive beyond a time when they can have a meaningful life and the questions that face the medical profession on making those decisions.

I had one question about the balloon angioplasty study that was released today. It was a $30 million study. They anticipate, as I

recall, about a $400 million savings. In a system like you are proposing, how would that decision be made and transmitted to physicians?

I mean, this morning as I was reading and listening to that report it dawned on me that as a physician in a small community I'm not sure that malpractice insurance would allow me not to try the balloon angioplasty on a heart attack patient as they came into a rural hospital and what the hospital administrator would say when he says Dr. Bruce, I notice that you are now doing no balloon angioplasties and we got all this equipment sitting around. We are really needing a lot more of those procedures performed.

How does the system keep that—what are you saying? You don't do those on heart attack patients that get to the hospital within 4 hours?

Mr. SIMMONS. Basically, that's exactly what ultimately this proposal we have is saying. First of all, we have to develop a stable—here we are, spending $600 billion a year for health care and virtually not a cent in comparison to find out whether we should be doing it in the first place.

Now, that's about as irrational an investment decision that a society can make. What we are saying is that that has got to be corrected and that's got to be corrected with a stable large source of funding which is administered under priorities set by a very knowledgeable group and that research administered—and one of the suggestions was through the Federal Government. That research then to be turned into guidelines and standards that are made available to the payers, providers and American people.

That ties into a beginning solution to the malpractice problem. You can't be sued if the standard says that you shouldn't be doing an angio plasty within 4 hours of surgery and uncomplicated MI. That's the standard.

We really think there's a systemic approach here, and unless we do it systemically, we will never get to the bottom of it. In response to your comment on the President, one of the nice things about what we are talking about is—the President said read my lips, no new taxes. As a matter of fact, if we spent a half trillion dollars differently, we could provide all the health care this society needs at a good quality, with universal access. But it is going to, again, take some very painful decisions.

It is possible to do. It will just be painful.

Mr. WAXMAN. Thank you. Mr. Bruce's time has expired. Mr. Rogers do you want to make a concluding comment?

Mr. ROGERS. I just wanted to say this, Mr. Chairman. They did a study in New Hampshire on prostatism—I don't think I would want one done on me. Just the word sounds bad. They found out that many of them were not necessary. The doctors didn't really know that the death rate was as high from that procedure as the facts show it is.

As soon as they put that information out to the medical profession in that area, that procedure dropped 15 percent right off. If we do begin to get this information out, it will have an impact and will have an impact on cost as well as good care. I think that's the way we are going to have to move.

Mr. WAXMAN. Thank you very much. Many of us have so many more questions, some of which we are going to submit in writing and ask you to respond to. I think that we may well want to schedule another time just to have an informal meeting to discuss and talk through some of these ideas.

Thank you very much for your testimony today and your excellent hard work in developing the report.

Mr. ROGERS. Thank you, Mr. Chairman. We are grateful to have been able to be here.

Mr. WAXMAN. We are going to break now until 1:30. We will convene back in this room at 1:30 sharp.

[Whereupon, at 12:20 p.m., the hearing was recessed for lunch, to reconvene this same day at 1:30 p.m.]

AFTER RECESS

Mr. WAXMAN. The meeting of the subcommittee will come back to order. Our final panel includes four other proposals for expanding health care coverage. They will be described by Dr. Issac Taylor for Physicians for a National Health Program; the Honorable James Tallon for Health Policy Agenda for the American People; Professor Richard Kronick of the Kronick Plan; and Carl Schramm for the Health Insurance Association of America.

Assemblyman Tallon is accompanied by Kenneth Thorpe, director of the Program on Health Financing and Insurance at Harvard School of Public Health.

We are pleased to welcome you to our hearing today. Your prepared statements will be put into the record in full. We would like to ask each of you, if you would, to summarize or otherwise give us your oral presentation in no more than 5 minutes.

Let me call on Dr. Taylor first.

STATEMENTS OF ISSAC M. TAYLOR, ON BEHALF OF PHYSICIANS FOR A NATIONAL HEALTH PROGRAM; CARL J. SCHRAMM, PRESIDENT, HEALTH INSURANCE ASSOCIATION OF AMERICA; JAMES R. TALLON, JR., CHAIRMAN, AD HOC COMMITTEE ON MEDICAID, HEALTH POLICY AGENDA FOR THE AMERICAN PEOPLE, ACCOMPANIED BY KENNETH E. THORPE, ASSISTANT PROFESSOR OF ECONOMICS, SCHOOL OF PUBLIC HEALTH, HARVARD UNIVERSITY; AND RICHARD KRONICK, DEPARTMENT OF COMMUNITY AND FAMILY MEDICINE, UNIVERSITY OF CALIFORNIA, SAN DIEGO

Mr. TAYLOR. Thank you, Mr. Chairman. I will take a minute to catch my breath. I am Issac Taylor and from Boston, MA, retired physician and former dean of the Medical School of the University of North Carolina.

I represent Physicians for a National Health Program, a national organization of over 1,900 doctors deeply concerned about the effect of deterioration of our system of medical care delivery and financing, upon the practice of medicine and the availability of medical care, the operation of hospitals and other health care institutions, and the cost of health care.

We feel a crisis is at hand that can be met only by fundamentally new approaches developed under Federal mandate and imple-

mented nationwide. We developed a broad proposal which we hope will receive wide attention and contribute to the thoughtful and extensive national discussion and debate which must occur if we are to resolve the present crisis.

We call for basic changes, not in the delivery of health services, that is patient/doctor relationships or how hospitals operate, but in the mechanism of financing of health services. We would preserve existing patterns of care, private practice, HMO's, group practice, private and government hospitals. We would change the method of paying for health services.

We propose that the chaos of multiple funding sources, hundreds of private insurance plans, multiple government plans, various employment health insurance schemes be replaced by a single funding source, federally mandated and eventually federally funded.

Our plan resembles the Canadian national health program about which we heard a lot about this morning. The plan would be national in scope, but we hope administered at a State or local level. Our proposal is detailed in an article in the January 12 issue of the New England Journal of Medicine. A reprint of that is appended to the written statement.

Quoting from the public summary of our plan, we propose a national health program that would one, fully cover everyone under a single comprehensive public insurance plan; two, pay hospitals and nursing homes a total annual amount to cover all operating expenses; three, fund capital costs through separate appropriations; four, pay for physician services and ambulatory services in one of three ways. Through fee-for-service payments with a simplified fee schedule and mandatory acceptance of the national health service payment as a total payment for service or procedure through the global budgets of hospitals and clinics employing salaried positions or on a per capita basis, five, we propose that the plan be funded at least initially from the same sources as at present. Six, that the plan contain costs through savings on billings and bureaucracy, improved health planning and the ability of the national health program as the single payer for services to establish overall spending limits.

Every resident of the United States would have equal access to health services without out-of-pocket costs. Existing patterns of health care would not be disrupted and the costly process of billing multiple third-party payers would be eliminated.

In the 1986 paper cited this morning by Mr. Scheuer, two of our members showed that 23 percent of U.S. health care costs went to administration. We estimate that the system that we propose would save $50 billion per year now spent on billing and extreme and excess bureaucracy. This would cover much of the cost of additional care for the millions who are now grossly underserved.

We think it is very important that the private insurance industry be removed from health care financing. Twelve percent of private health insurance premiums go to profits and overhead, while with Medicare which is our existing government insurance, overhead is only 3 percent.

To these private costs is added the cost we must now bear of billing multiple payers from doctor's offices and huge hospital billing departments. Mr. Peter Hiram, former Insurance Commissioner of

Massachusetts has concluded that the insurance industry is incapable of doing the job with health insurance. He says that a major requirement of an insurance company is to minimize the number of high risk clients enrolled.

In health insurance, of course, it is precisely the highest risk population that needs the most assistance. We think this assistance must be provided by government. Yesterday, Mr. Hiam gave me a letter addressed to the Chairman setting forth his views. With your permission, I would like to ask that letter be made part of the record.

In summary, Mr. Chairman, American health care financing is chaotic to the point of crisis. Millions are inadequately served while costs are out of control. Private health insurance cannot provide the answer. Plans seeking solution through extension of private insurance availability will fail. Government attempts to fill gaps without basic comprehensive reform will be ineffective and exorbitantly expensive.

Canada provides a model with much promise to the United States, the model providing equitable access for all with the possibility of effective cost control.

Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you very much, Dr. Taylor. Without objection, that attached letter will be part of your statement in the record.

[An attachment to Mr. Taylor's prepared statement and the letter referred to follow:]

A NATIONAL HEALTH PROGRAM FOR THE UNITED STATES

A Physicians' Proposal

David U. Himmelstein, M.D., Steffie Woolhandler, M.D., M.P.H.,
and the Writing Committee of the Working Group on Program Design*

Abstract Our health care system is failing. Tens of millions of people are uninsured, costs are skyrocketing, and the bureaucracy is expanding. Patchwork reforms succeed only in exchanging old problems for new ones. It is time for basic change in American medicine. We propose a national health program that would (1) fully cover everyone under a single, comprehensive public insurance program; (2) pay hospitals and nursing homes a total (global) annual amount to cover all operating expenses; (3) fund capital costs through separate appropriations; (4) pay for physicians' services and ambulatory services in any of three ways: through fee-for-service payments with a simplified fee schedule and mandatory acceptance of the national health program payment as the total payment for a service or procedure (assignment), through global budgets for hospitals and clinics employing salaried physicians, or on a per capita basis (capitation); (5) be funded, at least initially, from the same sources as at present, but with all payments disbursed from a single pool; and (6) contain costs through savings on billing and bureaucracy, improved health planning, and the ability of the national health program, as the single payer for services, to establish overall spending limits. Through this proposal, we hope to provide a pragmatic framework for public debate of fundamental health-policy reform. (N Engl J Med 1989; 320:102-8.)

OUR health care system is failing. It denies access to many in need and is expensive, inefficient, and increasingly bureaucratic. The pressures of cost control, competition, and profit threaten the traditional tenets of medical practice. For patients, the misfortune of illness is often amplified by the fear of financial ruin. For physicians, the gratifications of healing often give way to anger and alienation. Patchwork reforms succeed only in exchanging old problems for new ones. It is time to change fundamentally the trajectory of American medicine — to develop a comprehensive national health program for the United States.

We are physicians active in the full range of medical endeavors. We are primary care doctors and surgeons, psychiatrists and public health specialists, pathologists and administrators. We work in hospitals, clinics, private practices, health maintenance organizations (HMOs), universities, corporations, and public agencies. Some of us are young, still in training; others are greatly experienced, and some have held senior positions in American medicine.

As physicians, we constantly confront the irrationality of the present health care system. In private practice, we waste countless hours on billing and bureaucracy. For uninsured patients, we avoid procedures, consultations, and costly medications. Diagnosis-related groups (DRGs) have placed us between administrators demanding early discharge and elderly patients with no one to help at home — all the while glancing over our shoulders at the peer-review organization. In HMOs we walk a tightrope between thrift and penuriousness, too often under the pressure of surveillance by bureaucrats more concerned with the bottom line than with other measures of achievement. In public health work we are frustrated in the face of plenty; the world's richest health care system is unable to ensure such basic services as prenatal care and immunizations.

Despite our disparate perspectives, we are united by dismay at the current state of medicine and by the conviction that an alternative must be developed. We hope to spark debate, to transform disaffection with what exists into a vision of what might be. To this end, we submit for public review, comment, and revision a working plan for a rational and humane health care system — a national health program.

We envisage a program that would be federally mandated and ultimately funded by the federal government but administered largely at the state and local level. The proposed system would eliminate financial barriers to care; minimize economic incentives for both excessive and insufficient care, discourage administrative interference and expense, improve the distribution of health facilities, and control costs by curtailing bureaucracy and fostering health planning. Our plan borrows many features from the Canadian national health program and adapts them to the unique circumstances of the United States. We suggest that, as in Canada's provinces, the national

From the Working Group on Program Design, Physicians for a National Health Program, Center for National Health Program Studies, Cambridge Hospital–Harvard Medical School, 1493 Cambridge St., Cambridge, MA 02139, where reprint requests should be addressed to Dr. Himmelstein.

*This proposal was drafted by a 30-member Writing Committee, then reviewed and endorsed by 412 other physicians representing virtually every state and medical specialty. A full list of the endorsers is available on request. The members of the Writing Committee were as follows: David U. Himmelstein, M.D., Cambridge, Mass. (cochair); Steffie Woolhandler, M.D., M.P.H., Cambridge, Mass. (cochair); Thomas S. Bodenheimer, M.D., San Francisco; David H. Bor, M.D., Cambridge, Mass.; Christine K. Cassel, M.D., Chicago; Mardge Cohen, M.D., Chicago; David A. Danielson, M.P.H., Newton, Mass.; Alan Drabkin, M.D., Cambridge, Mass.; Paul Epstein, M.D., Brookline, Mass.; Kenneth Frisof, M.D., Cleveland; Howard Frumkin, M.D., M.P.H., Philadelphia; Martha S. Gerrity, M.D., Chapel Hill, N.C.; Jerome D. Gorman, M.D., Richmond, Va.; Michelle D. Holmes, M.D., Cambridge, Mass.; Henry S. Kahn, M.D., Atlanta; Robert S. Lawrence, M.D., Cambridge, Mass.; Joanne Lukomnik, M.D., Bronx, N.Y.; Arthur Mazer, M.P.H., Cambridge, Mass.; Alan Meyers, M.D., Boston; Patrick Murray, M.D., Cleveland; Vicente Navarro, M.D., Dr.P.H., Baltimore; Peter Orris, M.D., Chicago; David C. Parish, M.D., M.P.H., Macon, Ga.; Richard J. Pels, M.D., Boston; Leonard S. Rodberg, Ph.D., New York City; Jeffrey Scavron, M.D., Springfield, Mass.; Gordon Schiff, M.D., Chicago; Isaac M. Taylor, M.D., Boston; Howard Waitzkin, M.D., Ph.D., Anaheim, Calif.; Paul H. Wise, M.D., M.P.H., Boston; and William Zinn, M.D., Cambridge, Mass.

Reprinted from the *New England Journal of Medicine*
320:102-108 (January 12), 1989

health program be tested initially in statewide demonstration projects. Thus, our proposal addresses both the structure of the national health program and the transition process necessary to implement the program in a single state. In each section below, we present a key feature of the proposal, followed by the rationale for our approach. Areas such as long-term care; public, occupational, environmental, and mental health; and medical education need much more development and will be addressed in detail in future proposals.

Coverage

Everyone would be included in a single public plan covering all medically necessary services, including acute, rehabilitative, long-term, and home care; mental health services; dental services; occupational health care; prescription drugs and medical supplies; and preventive and public health measures. Boards of experts and community representatives would determine which services were unnecessary or ineffective, and these would be excluded from coverage. As in Canada, alternative insurance coverage for services included under the national health program would be eliminated, as would patient copayments and deductibles.

Universal coverage would solve the gravest problem in health care by eliminating financial barriers to care. A single comprehensive program is necessary both to ensure equal access to care and to minimize the complexity and expense of billing and administration. The public administration of insurance funds would save tens of billions of dollars each year. The more than 1500 private health insurers in the United States now consume about 8 percent of revenues for overhead, whereas both the Medicare program and the Canadian national health program have overhead costs of only 2 to 3 percent. The complexity of our current insurance system, with its multiplicity of payers, forces U.S. hospitals to spend more than twice as much as Canadian hospitals on billing and administration and requires U.S. physicians to spend about 10 percent of their gross incomes on excess billing costs.[1] Eliminating insurance programs that duplicated the national health program coverage, though politically thorny, would clearly be within the prerogative of the Congress.[2] Failure to do so would require the continuation of the costly bureaucracy necessary to administer and deal with such programs.

Copayments and deductibles endanger the health of poor people who are sick,[3] decrease the use of vital inpatient medical services as much as they discourage the use of unnecessary ones,[4] discourage preventive care,[5] and are unwieldy and expensive to administer. Canada has few such charges, yet health costs are lower than in the United States and have risen slowly.[6,7] In the United States, in contrast, increasing copayments and deductibles have failed to slow the escalation of costs.

Instead of the confused and often unjust dictates of insurance companies, a greatly expanded program of technology assessment and cost-effectiveness evaluation would guide decisions about covered services, as well as about the allocation of funds for capital spending, drug formularies, and other issues.

Payment for Hospital Services

Each hospital would receive an annual lump-sum payment to cover all operating expenses — a "global" budget. The amount of this payment would be negotiated with the state national health program payment board and would be based on past expenditures, previous financial and clinical performance, projected changes in levels of services, wages and other costs, and proposed new and innovative programs. Hospitals would not bill for services covered by the national health program. No part of the operating budget could be used for hospital expansion, profit, marketing, or major capital purchases or leases. These expenditures would also come from the national health program fund, but monies for them would be appropriated separately.

Global prospective budgeting would simplify hospital administration and virtually eliminate billing, thus freeing up substantial resources for increased clinical care. Before the nationwide implementation of the national health program, hospitals in the states with demonstration programs could bill out-of-state patients on a simple per diem basis. Prohibiting the use of operating funds for capital purchases or profit would eliminate the main financial incentive for both excessive intervention (under fee-for-service payment) and skimping on care (under DRG-type prospective-payment systems), since neither inflating revenues nor limiting care could result in gain for the institution. The separate appropriation of funds explicitly designated for capital expenditures would facilitate rational health planning. In Canada, this method of hospital payment has been successful in containing costs, minimizing bureaucracy, improving the distribution of health resources, and maintaining the quality of care.[6-9] It shifts the focus of hospital administration away from the bottom line and toward the provision of optimal clinical services.

Payment for Physicians' Services, Ambulatory Care, and Medical Home Care

To minimize the disruption of existing patterns of care, the national health program would include three payment options for physicians and other practitioners: fee-for-service payment, salaried positions in institutions receiving global budgets, and salaried positions within group practices or HMOs receiving per capita (capitation) payments.

Fee-for-Service Payment

The state national health program payment board and a representative of the fee-for-service practition-

ers (perhaps the state medical society) would negotiate a simplified, binding fee schedule. Physicians would submit bills to the national health program on a simple form or by computer and would receive extra payment for any bill not paid within 30 days. Payments to physicians would cover only the services provided by physicians and their support staff and would exclude reimbursement for costly capital purchases of equipment for the office, such as CT scanners. Physicians who accepted payment from the national health program could bill patients directly only for uncovered services (as is done for cosmetic surgery in Canada).

Global Budgets

Institutions such as hospitals, health centers, group practices, clinics serving migrant workers, and medical home care agencies could elect to receive a global budget for the delivery of outpatient, home care, and physicians' services, as well as for preventive health care and patient-education programs. The negotiation process and the regulations covering capital expenditures and profits would be similar to those for inpatient hospital services. Physicians employed in such institutions would be salaried.

Capitation

HMOs, group practices, and other institutions could elect to be paid fees on a per capita basis to cover all outpatient care, physicians' services, and medical home care. The regulations covering the use of such payments for capital expenditures and for profits would be similar to those that would apply to hospitals. The capitation fee would not cover inpatient services (except care provided by a physician), which would be included in hospitals' global budgets. Selective enrollment policies would be prohibited, and patients would be permitted to leave an HMO or other health plan with appropriate notice. Physicians working in HMOs would be salaried, and financial incentives to physicians based on the HMO's financial performance would be prohibited.

The diversity of existing practice arrangements, each with strong proponents, necessitates a pluralistic approach. Under all three proposed options, capital purchases and profits would be uncoupled from payments to physicians and other operating costs — a feature that is essential for minimizing entrepreneurial incentives, containing costs, and facilitating health planning.

Under the fee-for-service option, physicians' office overhead would be reduced by the simplification of billing.[1] The improved coverage would encourage preventive care.[10] In Canada, fee-for-service practice with negotiated fee schedules and mandatory assignment (acceptance of the assigned fee as total payment) has proved to be compatible with cost containment, adequate incomes for physicians, and a high level of access to and satisfaction with care on the part of patients.[6,7] The Canadian provinces have responded to the inflationary potential of fee-for-service payment in various ways: by limiting the number of physicians, by monitoring physicians for outlandish practice patterns, by setting overall limits on a province's spending for physicians' services (thus relying on the profession to police itself), and even by capping the total reimbursement of individual physicians. These regulatory options have been made possible (and have not required an extensive bureaucracy) because all payment comes from a single source. Similar measures might be needed in the United States, although our penchant for bureaucratic hypertrophy might require a concomitant cap on spending for the regulatory apparatus. For example, spending for program administration and reimbursement bureaucracy might be restricted to 3 percent of total costs.

Global budgets for institutional providers would eliminate billing, while providing a predictable and stable source of income. Such funding could also encourage the development of preventive health programs in the community, such as education programs on the acquired immunodeficiency syndrome (AIDS), whose costs are difficult to attribute and bill to individual patients.

Continuity of care would no longer be disrupted when patients' insurance coverage changed as a result of retirement or a job change. Incentives for providers receiving capitation payments to skimp on care would be minimized, since unused operating funds could not be devoted to expansion or profit.

Payment for Long-Term Care

A separate proposal for long-term care is under development, guided by three principles. First, access to care should be based on need rather than on age or ability to pay. Second, social and community-based services should be expanded and integrated with institutional care. Third, bureaucracy and entrepreneurial incentives should be minimized through global budgeting with separate funding for capital expenses.

Allocation of Capital Funds, Health Planning, and Return on Equity

Funds for the construction or renovation of health facilities and for purchases of major equipment would be appropriated from the national health program budget. The funds would be distributed by state and regional health-planning boards composed of both experts and community representatives. Capital projects funded by private donations would require approval by the health-planning board if they entailed an increase in future operating expenses.

The national health program would pay owners of for-profit hospitals, nursing homes, and clinics a reasonable fixed rate of return on existing equity. Since

virtually all new capital investment would be funded by the national health program, it would not be included in calculating the return on equity.

Current capital spending greatly affects future operating costs, as well as the distribution of resources. Effective health planning requires that funds go to high-quality, efficient programs in the areas of greatest need. Under the existing reimbursement system, which combines operating and capital payments, prosperous hospitals can expand and modernize, whereas impoverished ones cannot, regardless of the health needs of the population they serve or the quality of services they provide. The national health program would replace this implicit mechanism for distributing capital with an explicit one, which would facilitate (though not guarantee) allocation on the basis of need and quality. Insulating these crucial decisions from distortion by narrow interests would require the rigorous evaluation of the technology and assessment of needs, as well as the active involvement of providers and patients.

For-profit providers would be compensated for existing investments. Since new for-profit investment would be barred, the proprietary sector would gradually shrink.

Public, Environmental, and Occupational Health Services

Existing arrangements for public, occupational, and environmental health services would be retained in the short term. Funding for preventive health care would be expanded. Additional proposals dealing with these issues are planned.

Prescription Drugs and Supplies

An expert panel would establish and regularly update a list of all necessary and useful drugs and outpatient equipment. Suppliers would bill the national health program directly for the wholesale cost, plus a reasonable dispensing fee, of any item in the list that was prescribed by a licensed practitioner. The substitution of generic for proprietary drugs would be encouraged.

Funding

The national health program would disburse virtually all payments for health services. The total expenditure would be set at the same proportion of the gross national product as health costs represented in the year preceding the establishment of the national health program. Funds for the national health program could be raised through a variety of mechanisms. In the long run, funding based on an income tax or other progressive tax might be the fairest and most efficient solution, since tax-based funding is the least cumbersome and least expensive mechanism for collecting money. During the transition period in states with demonstration programs, the following structure would mimic existing funding patterns and minimize economic disruption.

Medicare and Medicaid

All current federal funds allocated to Medicare and Medicaid would be paid to the national health program. The contribution of each program would be based on the previous year's expenditures, adjusted for inflation. Using Medicare and Medicaid funds in this manner would require a federal waiver.

State and Local Funds

All current state and local funds for health care expenditures, adjusted for inflation, would be paid to the national health program.

Employer Contributions

A tax earmarked for the national health program would be levied on all employers. The tax rate would be set so that total collections equaled the previous year's statewide total of employers' expenditures for health benefits, adjusted for inflation. Employers obligated by preexisting contracts to provide health benefits could credit the cost of those benefits toward their national health program tax liability.

Private Insurance Revenues

Private health insurance plans duplicating the coverage of the national health program would be phased out over three years. During this transition period, all revenues from such plans would be turned over to the national health program, after the deduction of a reasonable fee to cover the costs of collecting premiums.

General Tax Revenues

Additional taxes, equivalent to the amount now spent by individual citizens for insurance premiums and out-of-pocket health costs, would be levied.

It would be critical for all funds for health care to flow through the national health program. Such single-source payment (monopsony) has been the cornerstone of cost containment and health planning in Canada. The mechanism of raising funds for the national health program would be a matter of tax policy, largely separate from the organization of the health care system itself. As in Canada, federal funding could attenuate inequalities among the states in financial and medical resources.

The transitional proposal for demonstration programs in selected states illustrates how monopsony payment could be established with limited disruption of existing patterns of health care funding. The employers' contribution would represent a decrease in costs for most firms that now provide health insurance and an increase for those that do not currently pay for benefits. Some provision might be needed to cushion the impact of the change on financially strapped small

98-680 0 - 89 - 3

businesses. Decreased individual spending for health care would offset the additional tax burden on individual citizens. Private health insurance, with its attendant inefficiency and waste, would be largely eliminated. A program of job placement and retraining for insurance and hospital-billing employees would be an important component of the program during the transition period.

Discussion

The Patient's View

The national health program would establish a right to comprehensive health care. As in Canada, each person would receive a national health program card entitling him or her to all necessary medical care without copayments or deductibles. The card could be used with any fee-for-service practitioner and at any institution receiving a global budget. HMO members could receive nonemergency care only through their HMO, although they could readily transfer to the non-HMO option.

Thus, patients would have a free choice of providers, and the financial threat of illness would be eliminated. Taxes would increase by an amount equivalent to the current total of medical expenditures by individuals. Conversely, individuals' aggregate payments for medical care would decrease by the same amount.

The Practitioner's View

Physicians would have a free choice of practice settings. Treatment would no longer be constrained by the patient's insurance status or by bureaucratic dicta. On the basis of the Canadian experience, we anticipate that the average physician's income would change little, although differences among specialties might be attenuated.

Fee-for-service practitioners would be paid for the care of anyone not enrolled in an HMO. The entrepreneurial aspects of medicine — with the attendant problems as well as the possibilities — would be limited. Physicians could concentrate on medicine; every patient would be fully insured, but physicians could increase their incomes only by providing more care. Billing would involve imprinting the patient's national health program card on a charge slip, checking a box to indicate the complexity of the procedure or service, and sending the slip (or a computer record) to the physician-payment board. This simplification of billing would save thousands of dollars per practitioner in annual office expenses.[1]

Bureaucratic interference in clinical decision making would sharply diminish. Costs would be contained by controlling overall spending and by limiting entrepreneurial incentives, thus obviating the need for the kind of detailed administrative oversight that is characteristic of the DRG program and similar schemes. Indeed, there is much less administrative intrusion in day-to-day clinical practice in Canada (and most other countries with national health programs) than in the United States.[11,12]

Salaried practitioners would be insulated from the financial consequences of clinical decisions. Because savings on patient care could no longer be used for institutional expansion or profits, the pressure to skimp on care would be minimized.

The Effect on Other Health Workers

Nurses and other health care personnel would enjoy a more humane and efficient clinical milieu. The burdens of paperwork associated with billing would be lightened. The jobs of many administrative and insurance employees would be eliminated, necessitating a major effort at job placement and retraining. We advocate that many of these displaced workers be deployed in expanded programs of public health, health promotion and education, and home care and as support personnel to free nurses for clinical tasks.

The Effect on Hospitals

Hospitals' revenues would become stable and predictable. More than half the current hospital bureaucracy would be eliminated,[1] and the remaining administrators could focus on facilitating clinical care and planning for future health needs.

The capital budget requests of hospitals would be weighed against other priorities for health care investment. Hospitals would neither grow because they were profitable nor fail because of unpaid bills — although regional health planning would undoubtedly mandate that some expand and others close or be put to other uses. Responsiveness to community needs, the quality of care, efficiency, and innovation would replace financial performance as the bottom line. The elimination of new for-profit investment would lead to a gradual conversion of proprietary hospitals to not-for-profit status.

The Effect on the Insurance Industry

The insurance industry would feel the greatest impact of this proposal. Private insurance firms would have no role in health care financing, since the public administration of insurance is more efficient[1,13] and single-source payment is the key to both equal access and cost control. Indeed, most of the extra funds needed to finance the expansion of care would come from eliminating the overhead and profits of insurance companies and abolishing the billing apparatus necessary to apportion costs among the various plans.

The Effect on Corporate America

Firms that now provide generous employee health benefits would realize savings, because their contribution to the national health program would be less than their current health insurance costs. For example, health care expenditures by Chrysler, currently $5,300 annually per employee,[14] would fall to about

$1,600, a figure calculated by dividing the total current U.S. spending on health by private employers by the total number of full-time-equivalent, nongovernment employees. Since most firms that compete in international markets would save money, the competitiveness of U.S. products would be enhanced. However, costs would increase for companies that do not now provide health benefits. The average health care costs for employers would be unchanged in the short run. In the long run, overall health costs would rise less steeply because of improved health planning and greater efficiency. The funding mechanism ultimately adopted would determine the corporate share of those costs.

Health Benefits and Financial Costs

There is ample evidence that removing financial barriers to health care encourages timely care and improves health. After Canada instituted a national health program, visits to physicians increased among patients with serious symptoms.[15] Mortality rates, which were higher than U.S. rates through the 1950s and early 1960s, fell below those in the United States.[16] In the Rand Health Insurance Experiment, free care reduced the annual risk of dying by 10 percent among the 25 percent of U.S. adults at highest risk.[3] Conversely, cuts in California's Medicaid program led to worsening health.[17] Strong circumstantial evidence links the poor U.S. record on infant mortality with inadequate access to prenatal care.[18]

We expect that the national health program would cause little change in the total costs of ambulatory and hospital care; savings on administration and billing (about 10 percent of current health spending[1]) would approximately offset the costs of expanded services.[19,20] Indeed, current low hospital-occupancy rates suggest that the additional care could be provided at low cost. Similarly, many physicians with empty appointment slots could take on more patients without added office, secretarial, or other overhead costs. However, the expansion of long-term care (under any system) would increase costs. The experience in Canada suggests that the increased demand for acute care would be modest after an initial surge[21,22] and that improvements in health planning[8] and cost containment made possible by single-source payment[9] would slow the escalation of health care costs. Vigilance would be needed to stem the regrowth of costly and intrusive bureaucracy.

Unsolved Problems

Our brief proposal leaves many vexing problems unsolved. Much detailed planning would be needed to ease dislocations during the implementation of the program. Neither the encouragement of preventive health care and healthful life styles nor improvements in occupational and environmental health would automatically follow from the institution of a national health program. Similarly, racial, linguistic, geographic, and other nonfinancial barriers to access would persist. The need for quality assurance and continuing medical education would be no less pressing. High medical school tuitions that skew specialty choices and discourage low-income applicants, the underrepresentation of minorities, the role of foreign medical graduates, and other issues in medical education would remain. Some patients would still seek inappropriate emergency care, and some physicians might still succumb to the temptation to increase their incomes by encouraging unneeded services. The malpractice crisis would be only partially ameliorated. The 25 percent of judgments now awarded for future medical costs would be eliminated, but our society would remain litigious, and legal and insurance fees would still consume about two thirds of all malpractice premiums.[23] Establishing research priorities and directing funds to high-quality investigations would be no easier. Much further work in the area of long-term care would be required. Regional health planning and capital allocation would make possible, but not ensure, the fair and efficient allocation of resources. Finally, although insurance coverage for patients with AIDS would be ensured, the need for expanded prevention and research and for new models of care would continue. Although all these problems would not be solved, a national health program would establish a framework for addressing them.

Political Prospects

Our proposal will undoubtedly encounter powerful opponents in the health insurance industry, firms that do not now provide health benefits to employees, and medical entrepreneurs. However, we also have allies. Most physicians (56 percent) support some form of national health program, although 74 percent are convinced that most other doctors oppose it.[24] Many of the largest corporations would enjoy substantial savings if our proposal were adopted. Most significant, the great majority of Americans support a universal, comprehensive, publicly administered national health program, as shown by virtually every opinion poll in the past 30 years.[25,26] Indeed, a 1986 referendum question in Massachusetts calling for a national health program was approved two to one, carrying all 39 cities and 307 of the 312 towns in the commonwealth.[27] If mobilized, such public conviction could override even the most strenuous private opposition.

References

1. Himmelstein DU, Woolhandler S. Cost without benefit: administrative waste in U.S. health care. N Engl J Med 1986; 314:441-5.
2. Advisory opinion regarding House of Representatives Bill 85-H-7748 (No 86-269-MP. R.I. Sup. Ct. Jan 5, 1987).
3. Brook RH, Ware JE Jr, Rogers WH, et al. Does free care improve adults' health? Results from a randomized controlled trial. N Engl J Med 1983; 309:1426-34.

4. Siu AL, Sonnenberg FA, Manning WG, et al. Inappropriate use of hospitals in a randomized trial of health insurance plans. N Engl J Med 1986; 315:1259-66.
5. Brian EW, Gibbens SF. California's Medi-Cal copayment experiment. Med Care 1974; 12:Suppl 12:1-303.
6. Iglehart JK. Canada's health care system. N Engl J Med 1986; 315:202-8, 778-84.
7. *Idem.* Canada's health care system: addressing the problem of physician supply. N Engl J Med 1986; 315:1623-8.
8. Detsky AS, Stacey SR, Bombardier C. The effectiveness of a regulatory strategy in containing hospital costs: the Ontario experience, 1967-1981. N Engl J Med 1983; 309:151-9.
9. Evans RG. Health care in Canada: patterns of funding and regulation. In: McLachlan G, Maynard A, eds. The public/private mix for health: the relevance and effects of change. London: Nuffield Provincial Hospitals Trust, 1982:369-424.
10. Woolhandler S, Himmelstein DU. Reverse targeting of preventive care due to lack of health insurance. JAMA 1988; 259:2872-4.
11. Reinhardt UE. Resource allocation in health care: the allocation of lifestyles to providers. Milbank Q 1987; 65:153-76.
12. Hoffenberg R. Clinical freedom. London: Nuffield Provincial Hospitals Trust, 1987.
13. Horne JM, Beck RG. Further evidence on public versus private administration of health insurance. J Public Health Policy 1981; 2:274-90.
14. Cronin C. Next Congress to grapple with U.S. health policy, competitiveness abroad. Bus Health 1986; 4(2):55.
15. Enterline PE, Salter V, McDonald AD, McDonald JC. The distribution of medical services before and after "free" medical care — the Quebec experience. N Engl J Med 1973; 289:1174-8.
16. Roemer R, Roemer MI. Health manpower policy under national health insurance: the Canadian experience. Hyattsville, Md.: Health Resources Administration, 1977. (DHEW publication no. (HRA) 77-37.)
17. Lurie N, Ward NB, Shapiro MF, et al. Termination of Medi-Cal benefits: a follow-up study one year later. N Engl J Med 1986; 314:1266-8.
18. Institute of Medicine. Preventing low birthweight. Washington, D.C.: National Academy Press, 1985.
19. Newhouse JP, Manning WG, Morris CN, et al. Some interim results from a controlled trial of cost sharing in health insurance. N Engl J Med 1981; 305:1501-7.
20. Himmelstein DU, Woolhandler S. Free care: a quantitative analysis of the health and cost effects of a national health program. Int J Health Serv 1988; 18:393-9.
21. LeClair M. The Canadian health care system. In: Andreopoulos S, ed. National health insurance: can we learn from Canada? New York: John Wiley, 1975:11-92.
22. Evans RG. Beyond the medical marketplace: expenditure, utilization and pricing of insured health care in Canada. In: Andreopoulos S, ed. National health insurance: can we learn from Canada? New York: John Wiley, 1975:129-78.
23. Danzon PM. Medical malpractice: theory, evidence, and public policy. Cambridge, Mass.: Harvard University Press, 1985.
24. Colombotas J, Kirchner C. Physicians and social change. New York: Oxford University Press, 1986.
25. Navarro V. Where is the popular mandate? N Engl J Med 1982; 307:1516-8.
26. Pokorny G. Report card on health care. Health Manage Q 1988; 10(1):3-7.
27. Danielson DA, Mazer A. Results of the Massachusetts Referendum on a national health program. J Public Health Policy 1987; 8:28-35.

46 Fayerweather Street
Cambridge, MA 02138

March 8, 1989

Mr. Henry A. Waxman
Chairman, Subcommittee on Health and Environment
Committee on Energy and Commerce
U.S. House of Representatives
2415 Rayburn House Office Building
Washington, DC 20515

Dear Congressman Waxman:

I respectfully request that this letter be accepted as a part of the record of the hearing your subcommittee is holding on ways to improve and expand health insurance coverage.

As the former Chairman of the Massachusetts Health Facilities Rate Setting Commission (1978-1982) and the Massachusetts Commissioner of Insurance (1983-1987), I have been a close observer of the public and private health insurance system. On the basis of this experience I am offering the following comments concerning the feasibility of using the private insurance system in achieving universal access to health care and the advisability of expanding the role of the private health insurance market.

The private insurance system can certainly be expanded to cover more persons who now lack health insurance, but by its very nature it cannot become the vehicle for anything approaching universal health insurance. Insurers are discriminators. Central to their business is risk assessment and classification of risks. Insurers compete by varying benefits and premiums according to levels of risk, and by excluding altogether those classes of risks found to be "uninsurable", either because of pre-existing health conditions or because the known risk would require the charging of prohibitively large premiums.

Millions of Americans, including for example those who are HIV antibody positive, are presently uninsurable in the non-group and small group health insurance market. As genetic testing becomes more widespread, insurers will be able to assess risks with increasing accuracy and we can expect that additional millions of Americans now considered insurable will be denied health coverage.

As you may be aware, Massachusetts last year enacted legislation (Mass. St. 1988, Ch. 23) designed to achieve universal access to health

care by imposing tax penalties on employers who do not offer health benefits, and by the offer of comprehensive insurance through a state-supported residual market for the remaining uninsured.

No one knows yet how the Massachusetts experiment will work. It would not be surprising, however, if the effect of the new law turns out to be exactly the opposite of what was intended. Rather than persuading more businesses to offer health benefits, the inflationary effects of the new law and the creation of a comprehensive tax-supported entitlement program may persuade employers which now offer such benefits to reduce or drop them. And employees may find the comprehensive coverage of the entitlement program to be more attractive than the less generous health benefits sponsored by their employer. Any large-scale movement of employees to the new entitlement program would create a fiscal crisis for the state. The choices would be unpalatable: limit access to the entitlement program or raise taxes.

Even if your subcommittee limits its scope to consideration of measures which would merely expand private insurance coverage without any expectation that such an approach will lead to universal access to health care, I would urge you to consider carefully the disadvantages of such a policy. In my opinion, the private insurance system is ill-equipped to perform its present function, let alone an expanded role. I note particularly the following:

- By its nature, the insurance industry attempts to exclude those who have the most pressing health care needs. Paradoxically, expansion of coverage will provide access to health care to those who need it the least.

- The industry's underwriting practices are objectionable in a number of aspects and should not be expanded to cover additional Americans, especially those with existing health conditions. Particularly offensive is the industry's use of medical tests and the recording of test results and other medical information in a national data bank, available to the entire life and health industry throughout the United States and Canada.

- Because of its marketing methods the private insurance system, including health insurance, has extremely high administrative costs.

- The insurance industry is not subject to effective regulation and public oversight. The industry has successfully resisted any federal regulation, and it is exempt from most antitrust laws.

The present health care financing system has many deficiencies, chief of which is that it fails to cover the health care costs of millions of Americans. What is needed is thorough reform. Anything less will not suffice.

Yours very truly,

Peter Hiam

Peter Hiam

Mr. WAXMAN. Mr. Schramm, why don't we hear from you next.

STATEMENT OF CARL J. SCHRAMM

Mr. SCHRAMM. Thank you, Mr. Chairman. Thank you for your invitation to come before you today. As you know, I am the President for the Health Insurance Association of America. Our 350 member companies write health insurance for over 90 million Americans.

One year ago last month in February, the board of the Health Insurance Association of America adopted a four point proposal aimed at providing insurance for the 34 to 38 million people without health insurance. We have attempted a comprehensive solution, and we have been steadily at work on improvements to our scheme. Only last month, the board has approved further detailed development of our proposals around Medicaid, which I would like to share with you today.

I just say as a preamble, we view 34 to 38 million people without health insurance as a fundamental threat to the current way that the American health care system is financed, that with the dual threat of runaway costs in the provider sector present a great challenge to the government into our industry in terms of what we do to preserve a system that has worked well in general but has, in fact, left some people out.

What I would like to do today is really talk about our four point plan. The fundamental premise of our proposal is that the task is made complex by the character of the population. Without health insurance, roughly 3 in 10 are below the Federal poverty level; 3 in 10 are the near poor between 100 and 200 percent of the poverty level; and 4 in 10 without insurance are above 200 percent of the poverty level.

Eleven percent of the uninsured are self-employed in their families; 13 percent are half-time employees in their families; and 51 percent are fulltime employees in their families. All of these factors make any single solution a difficult and we believe that it is important to try a multi-pronged approach.

Our four points are as follows. The first is that the public sector must take responsibility for the poor. Medicaid should be expanded. What I would like to do with regard to the public sector of Medicaid is really outline five points in detail and go quickly over the last three points of the overall four point plan.

As to the first plan in terms of the public sector taking responsibility for the poor, we would point out five specific items. First, Medicaid should be expanded to all Americans with incomes below the Federal poverty level regardless of family structure, age, or disability status. This should be the first priority for any new government funds. If available funds do not permit full coverage up to the poverty level, HIAA believes priorities should be given first to younger children, next to older children, and finally to other populations.

Priorities should also be placed on primary care and preventive services. Unlike some other populations, many poor children do not have access to major public health care financing programs such as Medicare. This priority also reflects the critical need children and pregnant women have for preventive services.

I might point out, Mr. Chairman, that the committee has before it specific legislation which would be a reasonable first step along the road to assuring everyone equal availability of care. In H.R. 833, the Health Amendments of 1989 sponsored by you and cosponsored by other members of this subcommittee, we believe deserves early consideration and has our full support. Unless we are able to give all poor women and their young proper care, the uninsurance gap will remain.

The second point on the Medicaid frontier is, we believe that the linkage between Medicaid eligibility and cash assistance should be severed.

The third point I would like spell out really relates to the proposal regarding a Medicaid buy-in. We believe that individuals and families with income above poverty but below 150 percent of the Federal poverty standard and with limited assets, should be eligible to purchase first coverage of a limited package of primary preventative and related ambulatory care through their State's Medicaid program.

A sliding scale of premiums should be developed so that at the upper end of the income range the charge would approximately the actuarial value of the coverage, not to exceed 15 percent of the families income in excess of the Federal poverty standard.

We are developing a specific benefit package proposal that would cost about $50 to $60 per month for a family of three.

The fourth point that I want to talk about is what we propose calling a spend down proposal. It would cover persons who would not otherwise be eligible for Medicaid due to higher incomes. They should be able to be eligible for full Medicaid coverage once out of pocket medical expenses reduce their remaining income to the Federal poverty level.

The asset test should be adjusted to assure that the home, the cost of a standard car would be protected, but would avoid incentives to drop private insurance and limit the use of liquid assets in the house.

The fifth point would be to establish a Medicaid buy-out program which would give State Medicaid programs the option of paying the expenses such as premiums and deductibles of the working poor who might be eligible for coverage under their employer's group plans.

The employer program would be primary to Medicaid. States should also be allowed to have the option of paying the employee's share of available group coverage during the first year after a worker loses regular eligibility for Medicaid.

The remaining three points of our program I will summarize very quickly. The second would be that insurers should be allowed to offer more affordable coverage, including prototype plans. We believe ERISA and State mandated benefits should be extended to insured employee plans as well as to self-insured plans so that insurers can design less expensive benefit packages for small business.

I think what we really are arguing is that to some extent we are disabled in the market from providing regular Med-surge care. There are conservative estimates that suggest up to 9.1 million

people are counted among our 34 to 38 million uninsured because of the cost of mandated benefits at the State level.

Mr. WAXMAN. Mr. Schramm, the rest of that statement is going to be in the record.

[Testimony resumes on p. 83.]

[The prepared statement of Mr. Schramm follows:]

REMARKS

BY

CARL J. SCHRAMM
PRESIDENT
HEALTH INSURANCE ASSOCIATION OF AMERICA

I am Carl J. Schramm, President, Health Insurance Association of America. HIAA is a trade association representing some 350 insurance companies who write approximately 40 percent of the health insurance in this country. The combined efforts of HIAA's members, the Blue Cross-Blue Shield plans and HMOs have succeeded in protecting 180 million Americans. However, we recognize that this is not enough.

Mr. Chairman, our member companies are greatly concerned about those 35 million Americans who do not enjoy the protection of health insurance. Over the last two years, our membership has worked hard to develop creative solutions for extending health care benefits to uninsured groups and individuals. On behalf of HIAA, I am pleased to report a commitment among our companies to work with government in implementing effective approaches for providing coverage to this population.

The task of ensuring that all Americans enjoy the protection of insurance is complex. This complexity is largely a function of the heterogeneity of the uninsured population; this heterogeneity requires a combination of private and public solutions.

Roughly three in ten of the uninsured are poor (with family income below 100% of the federal poverty level); three in ten are low income (between 100% and 200% of the poverty level); and four in ten are non-poor (above 200% of the poverty level).

Eleven percent of the uninsured are the self-employed and their families; 13 percent are half-time employees and their families; and 51 percent are full-time employees and their families.

Finally, uninsured workers are disproportionately employed in certain industries (retail trade and services) and by smaller firms.

All of the above factors make formulating any strategy for a public/private solution difficult. As such we see the need to address the special needs of the various subpopulations within the 37 million uninsured with a simultaneous multi-pronged approach. We propose a specific four-point plan which, taken as a whole, provides a comprehensive blueprint to cover the uninsured:

The first part of our recommendations involves expansion of the Medicaid program. The members of this Subcommittee know, far better than I, the intricacies and shortcomings of Medicaid

eligibility, and the funding crisis that preserves them. HIAA knows that this Subcommittee has helped lead the fight and has succeeded in enacting important incremental improvements in Medicaid year after year. Because of your instrumental role in developing policy in this crucial area, I plan to spend additional time today discussing some of our latest thinking on Medicaid expansion.

A. Expansion of Basic Medicaid Coverage

Ultimately we would like to see all Americans with incomes below the federal poverty level (and with limited assets) eligible for Medicaid, regardless of family structure, age or disability status. Accomplishing this would require severing the linkage between Medicaid eligibility and cash assistance.

If available funds do not permit full coverage up to the poverty level, HIAA believes priority should be given first to younger children, next to older children and finally to other populations. Priority should also be placed on primary care and preventive services. Unlike some other populations, many poor children do not have access to federal health care financing programs other than Medicaid (i.e., Medicare). This priority also reflects the critical need that children and pregnant women have for preventive services.

B. Limited Medicaid Buy-In

Individuals and families with incomes above poverty but below 150 percent of the federal poverty level should be eligible to purchase first-dollar coverage of a limited package of primary, preventive and related ambulatory care through their state's Medicaid program.

The benefit package would include basic ambulatory services such as well-child care and immunizations, prenatal care, basic diagnostic services including laboratory tests and x-rays, primary treatment services, monitoring of chronic illness, and outpatient prescription drugs according to the state's Medicaid formulary. Inpatient services would not be covered, nor would outpatient drug or alcohol services, mental health services, cosmetic surgery, treatment of infertility, major outpatient surgical procedures, or home health care (other than maternity-related).

Such a limited benefit package meets the near-poor's need for access to basic primary care (so that illness does not become more severe and expensive through lack of treatment), while not significantly lessening employers' incentives to offer basic insurance protection. As employer plans often incorporate a

deductible in an amount which would be a relatively significant barrier for the near-poor, there should be only minimal overlap between buy-in benefits and employer-provided coverage.

The limited benefit package keeps costs of the buy-in coverage per se to a minimum, thus permitting very low premiums, constraining government costs, broadening participation, and reducing the chance of adverse selection. (Assuming realistic participation rates by eligible persons, our preliminary estimate of total federal and state costs of the buy-in is in the $1 billion range.)

A sliding scale of premiums should be developed so that, at the upper end of the income range, the charge would approximate the actuarial value of the coverage, not to exceed 15 percent of the family's income in excess of the federal poverty level. We are developing a specific benefit package proposal that would cost about $50-$60 per month for a family of three. If five income brackets were used, for example, the suggested monthly premium charges would be as follows:

Family Income as a Percent of Poverty	Monthly Premium Charge
100 - 109 %	$ 6
110 - 119 %	18
120 - 129 %	30
130 - 139 %	42
140 - 149 %	54
150 % + over	not eligible

Because some public subsidy is involved, eligibility would be restricted to persons with limited incomes who do not have substantial assets. However, the current Medicaid asset test should be liberalized to assure that working families would not have to impoverish themselves in order to obtain access to basic primary care. Homes, and cars of normal value, should be protected. The limit on liquid assets should be liberalized somewhat, perhaps to the $12,000 level Congress recently found acceptable for spouses of nursing home residents. A self-declaration process could be used to minimize administrative burden.

C. Spend-down

Persons not otherwise eligible for Medicaid due to higher income should become eligible for full Medicaid coverage once out-of-pocket medical expenses reduce their remaining income to the federal poverty level.

Some coverage of last resort is needed to cover inpatient care and other large out-of-pocket expenses for the near-poor who cannot afford to purchase private insurance on their own and whose employers do not offer it or offer only very limited coverage. Ensuring such coverage of last resort should be accomplished by requiring that all states establish "spend-down"

coverage at the federal poverty level. This would establish a uniform national eligibility policy for the more limited "medically needy" option, now used by 36 states. The asset test should be adjusted to assure that the home, and cars of normal value, would be protected; but, to avoid incentives to drop private insurance, the limit on liquid assets would be left to state discretion, as it is now.

The major current problem with spend-down -- it does not finance early access to primary and preventive care -- is remedied by making "buy-in" available for primary, preventive and related ambulatory care.

D. "Buy-Out"

HIAA also recommends that Medicaid eligibles who are working be encouraged to make use of employment-based health insurance, where it is available. To accomplish this goal, state Medicaid programs should be given the option of paying (and receiving federal matching funds for) the employee's share (if any) of the private insurance premium, as well as other costs. Medicaid would continue to be available to cover deductibles and other benefits not covered under the employer plan; and Medicaid's contribution, for the employee's premium plus Medicaid's "wrap-

around" coverage, would not be permitted to exceed the average cost of traditional Medicaid coverage.

Under our proposal, states would have the option of "buying out" two groups. First, more working people will qualify for Medicaid as the income level is raised to the poverty level for more persons and categorical restrictions are removed. Allowing states to pay the employee's premium share for any working Medicaid eligible seems a sensible way to reduce government outlays and encourage reliance on mainstream private, rather than government, benefits.

Second, current public policy supports the concept of encouraging low-income persons to work by easing the transition from public support to self support. One component of this policy is to integrate low-income persons returning to work into mainstream, work-provided benefits while continuing to provide government support for other necessary services during a transition period. The most recent example of this is the Welfare Reform Act, which extends Medicaid eligibility for 12 months after a family loses cash welfare payments because of a return to work and permits states to pay the employee's share of employer-provided health insurance.

As such, states should also have the option of paying the employee's share of available group coverage during the first year after the worker loses regular eligibility for Medicaid. For the first six months after loss of regular eligibility, there would be no income limit on eligibility for this premium subsidy. For the second six months, Medicaid payment of the employee's share could continue only for workers whose family income remained less than 150 percent of the federal poverty level. As under welfare reform, states would be allowed to charge a nominal premium during the second six months, based on the family's income as a percent of the federal poverty level.

For both the "buy out" of Medicaid eligibles and the "buy out" of individuals transitioning off Medicaid, participating employers should be required to make the same premium contribution on behalf of Medicaid-eligible employees as they do for other employees.

We believe that the federal government can rely on states to take advantage of the "buy out" option if and only if it is financially advantageous to the state and the federal government (considering the benefits available under the employer plan and the charge to the employer/state to obtain them.) Since the employee's share of employer-provided coverage will usually be significantly smaller than the amount Medicaid would expect to

pay to provide benefits directly, states would probably make extensive use of this option. While states should be permitted to make this decision on an employer plan-by-employer-plan basis, they must not be permitted to discriminate among individual employees.

This committee has before it legislation which would be a reasonable first step along the road to assuring everyone equal availability of care.

H.R. 833, for example, the Medicaid Child Health Amendments of 1989, sponsored by the chairman and co-sponsored by other members of this committee deserves early consideration and has our full support. Unless we are able to give all poor women and their young proper care, the uninsured gap will remain. More importantly any hope we have of closing the infant mortality gap will be seriously jeopardized.

2) As the second piece of our four point plan, insurers should be allowed to offer more affordable coverage, including prototype plans. ERISA preemption of state mandated benefits should be extended to insured employee plans as well as to self-insured plans so that insurers can design less expensive benefit packages for small businesses.

Ironically, while the more than 600 state mandates do not apply to the vast majority of large employer and union plans (which are self insured) they do apply to most small employers who simply cannot afford them. A study by a respected health economist at the University of Illinois estimates that as many as 16 percent of uninsured small employers fail to offer coverage because of state service and provider mandates.

HIAA will also support statutory changes to enable insurers to make lower cost prototype plans available. All prototypes would be actuarially equivalent in value and include basic inpatient and outpatient physician, hospital and diagnostic services. Additional services, such as dental and mental health, would be offered in some of the prototypes in exchange for higher copayments. In all prototypes, managed care features would be permitted.

3) Coverage must be made available to all Americans. This is true, even for those whom insurers might normally decline due to existing high cost medical or occupational conditions. There are two components to consider here: uninsurable employer groups and uninsurable individuals.

To ensure access to affordable group coverage for all employees, a nonprofit organization should be established to reinsure high cost employer groups. Employers would access the reinsurance organization indirectly via insurers, or directly if unable to purchase coverage through an insurer. Losses incurred by the reinsurance organization could be financed entirely by the private sector if shared equitably among competitors in the small group market and all larger health plans whether insured or self-insured.

HIAA also seeks Federal legislation encouraging all states to enact a qualified state pool for medically uninsurable individuals. Such pools have already been enacted in 15 states. Each pool should be a nonprofit corporation with coverage available only to uninsurable individuals who are not eligible for coverage by employer plans, Medicare or Medicaid. Pool losses should be financed by state general revenues or any other broad based funding mechanism that does not assign losses disproportionately to any individual or corporate entity. In the absence of action by a state, the Secretary of the Department of Health and Human Services (HHS) should establish a qualified pool in that state, in which case losses, if any, would be paid from federal health funds the Secretary would otherwise spend in the state.

4) Small businesses should be given a greater incentive to provide coverage for their employees. Self-employed individuals should get a 100 percent deduction for their health insurance protection, as long as they provide equal coverage to their employees.

Our proposals are designed to meet the needs of a heterogeneous uninsured population. We believe that they should be given an opportunity to work before government turns to unnecessarily onerous mandates. Our four-point plan provides a blueprint for a truly comprehensive approach to solving the problem of the uninsured. The plan stresses the sharing of responsibility between government and the private sector. In our proposal we are calling on government to assist those who cannot be expected to pay for coverage on their own. We in turn will ensure that for everyone who can afford private coverage will be available.

Thank you.

Mr. WAXMAN. Mr. Tallon, we will hear from you.

STATEMENT OF JAMES TALLON

Mr. TALLON. Thank you, Mr. Chairman. I am Jim Tallon. I served as Chair of the ad-hoc Committee on Medicaid of the Health and Policy Agenda for the American People. We have appended to our testimony, our report Including the Poor, which was released in February.

I serve additionally as the Majority Leader of the New York State Assembly, where for 8 years I served as Chair of the Committee on Health. I am joined today by Professor Kenneth Thorpe, Assistant Professor of Economics at the School of Public Health at Harvard University. I will make some brief comments and turn to Professor Thorpe, and then I would like to conclude with a comment or two.

We concentrate on the 10.9 million people who are uninsured and who are below the poverty level. As you recognize, Mr. Chairman, about this population we may assume that the poor are more likely to be in need of service than the general population. We must also assume that the poor do not have the capacity to purchase coverage out of pocket. Therefore, if the poor are not covered by a program, it is more likely then in the general population that the poor are going to go with inadequate or with no services.

As we have looked at the Medicaid program in our examination, we highlight problems of restrictive eligibility criteria, varying eligibility criteria across the States, enormous variation in benefits not only in the number of services covered but in the degree to which those services are covered among the various States. And we notice difficulties in the patterns and manner of payment, which even when services are covered and people are eligible, may restrict access to providers of health care.

We call, Mr. Chairman, for Medicaid to be guided by national standards and goals. We call for Medicaid's link to categorical cash assistance programs to be broken and eligibility to be established at a minimum of 100 percent of the poverty level.

We call for the development of a standard benefits package, and we have outlined that benefits package in the report. We call for improvements in the provider payment systems to ensure that the poor actually get access to the care.

In Professor Thorpe's analysis, he has built that analysis looking first at eligibility, bringing eligibility to the poverty level across the States, then looking at coming to a standard benefits level and then on top of that, improving provider payments.

I will turn to Professor Thorpe for that analysis. Then, Mr. Chairman, I would like to conclude with just a few brief observations.

Mr. THORPE. The costs appended to this proposal are important, and I would like to briefly highlight the key results. As you will see, the costs are substantial. They underscore the magnitude of the problems that Mr. Tallon has highlighted.

With respect to providing coverage for the uninsured poor, we have estimated that it would cost approximately $9 billion tc extend health care coverage to approximately 11 million currently

uninsured poor. About 4 million of those would be children. The break out of that would be approximately $5 billion Federal expenditures and $4 billion State and local expenditures.

I should highlight though, that those expenditures that I have just discussed are not all new spending. For example, we estimated that approximately $4.2 billion of currently uncompensated care would be reduced through direct savings over time. We also have estimated that a portion of that, approximately $1.5 billion would represent direct savings to State and local governments through potential reductions in city and local tax levy supports.

In addition, such an expansion would also reduce out-of-pocket spending by the poor by approximately $2.5 billion. We also looked at the cost of providing standard Medicaid package. The package is described in the report. Our estimates are that such a package would cost not $9 but approximately $15 billion to provide a minimum standard across States.

The specifics of those I mentioned are highlighted in the report. Finally, the third piece that we looked at, the cost of providing access to Medicaid recipients essentially by providing payments at market rates. For example, we know that there is a large and growing gap between Medicaid reimbursement levels and physician fees. That has been consistently identified as a major factor limiting access to care by Medicaid paid recipients.

We have estimated that by raising Medicaid payments to physicians to Medicare levels that an additional $1.5 billion of expenditures would ensue. That, however, would purchase approximately 13.5 million more office visits for Medicaid recipients who are currently receiving care in institutional settings.

Finally, we also looked at the cost attendant to raising Medicaid payment rates to hospitals to simply the level of incurred costs. Our estimates of that were the incremental costs would be about $3 to $4 billion.

Mr. TALLON. Mr. Chairman, the portion of the poor population to be covered by an expanded Medicaid program is dependent on health coverage strategies that are adopted for the non-poor uninsured. For example, Professor Thorpe's analysis recognizes that an employer mandate is proposed in the Congress, would shift approximately half of the 11 million uninsured poor to the employer, that is private sector responsibility.

Furthermore, in the other direction, an absence of strategies to extend Medicaid coverage to the poor with individually purchased or group health plans would increase public sector responsibility.

Whatever the balance among these initiatives, there exists an unavoidable governmental responsibility for a large number of poor people with no coverage.

Mr. Chairman, as an elected official who has worked with this topic at length in my State as you have in the Congress, I would make just two quick observations.

First, I have found as Mr. Harris indicated this morning and as you have found, there is support among the people toward action in this area. Second and perhaps more importantly, as we all talk about the various approaches, what we have built on is the existing system.

I would emphasize and anticipate in the questions heard earlier by Mr. Bruce and by Mr. Richardson, that as an elected official building on the existing system does not present all of the difficulties attendant in redesign of existing characteristics which often bring negatives to the table. I think building on this existing system is consistent with a constructive strategy to improve coverage for the American people.

[Testimony resumes on p. 107.]

[The prepared statement and appendixes 1 and 3 of Mr. Tallon and Mr. Thorpe follow. Appendix 2, the final report of the ad hoc committee on Medicaid entitled "Including the Poor," has been retained in subcommittee files.]

STATEMENT OF HEALTH POLICY AGENDA FOR THE AMERICAN PEOPLE

BY JAMES R. TALLON, JR. AND KENNETH E. THORPE

My name is James R. Tallon, Jr. I am the Chairman of the Ad Hoc Committee on Medicaid of the Health Policy Agenda for the American People. I am also the majority leader of the New York State Assembly, where I previously chaired the Health Committee for eight years. We speak to you today about a subset of the uninsured population who are the most vulnerable. As our society comes to grips with guaranteeing access to the 37 million uncovered Americans, we cannot disregard the health care needs of those most in need of protection.

This subset is a large one, made of 10.9 million Americans living on incomes below the federal poverty standard. They are not eligible for Medicaid, the program this very institution helped create for them back in 1965. Additionally, 6.8 million more Americans below the poverty line are uncovered by Medicaid. About half of these buy their own coverage, and the others have coverage through employment.

The 11 million uncovered poor people make up a full third of the nation's population with incomes below the federal poverty level. Forty percent of the 11 million uncovered poor are children.

By any reasonable standard, Medicaid fails to meet the needs of a significant part of the population it was intended to serve.

The Ad Hoc Committee on Medicaid of the Health Policy Agenda spent 15 months evaluating the problems of the program and devising a plan for its restructure so that Medicaid will meet the health care needs of the poor. We undertook this evaluation cognizant of the other endeavors under way to expand health care coverage. While we welcome those endeavors, they do not focus on the needs of the poor. And if expanded health coverage is adopted without fully addressing those needs, the product will lack the comprehensiveness and coherence we all want it to achieve.

The gaps in Medicaid, a state-operated program, are attributable to a lack of uniform federal standards about who is eligible, what services are offered and how much providers are paid.

In addition to restrictive eligibility criteria, the benefit packages frequently limit care to the extent that patients cannot maintain their health. And too often, reimbursements paid to physicians and hospitals are so low that Medicaid recipients remain untreated.

PERMIT ME TO ILLUSTRATE THE CAPRICIOUS AND HURTFUL EFFECTS OF THESE INEQUITIES.

A FAMILY OF THREE IN ONE STATE MUST HAVE AN INCOME LESS THAN $1,416 A YEAR TO QUALIFY FOR MEDICAID. THE SAME FAMILY, IF IT HAD THE RESOURCES, COULD MOVE TO ANOTHER STATE, EARN UP TO $8,316 AND QUALIFY FOR THE PROGRAM.

A BABY IN ONE STATE CAN BE TAKEN TO THE DOCTOR FOR A WELL-BABY VISIT TWICE IN HIS FIRST TWO YEARS OF LIFE AND ONLY THREE MORE TIMES AFTER THAT UNTIL AGE 21. THE SAME BABY IN ANOTHER STATE CAN BE TAKEN TO THE DOCTOR 20 TIMES THROUGHOUT HIS CHILDHOOD.

IN MY OWN STATE OF NEW YORK, WHERE BENEFITS AND ELIGIBILITY ARE REASONABLY BROAD, MEDICAID PAYS DOCTORS WELL BELOW THE COST OF TREATING PATIENTS. THE RESULT IS THAT ROUGHLY HALF OF THE PHYSICIANS IN NEW YORK STATE DON'T REGULARLY PARTICIPATE IN MEDICAID.

NATIONWIDE, THAT FIGURE IS 25 PERCENT. AN EXAMPLE OF THE DISPARITIES IN REIMBURSEMENTS -- THE NATIONAL AVERAGE PAYMENT FOR OBSTETRICAL CARE IN THE PRIVATE SECTOR IS $3,440, BUT MEDICAID'S NATIONAL AVERAGE IS ONLY $1,310.

NATIONALLY, 12 STATES ARBITRARILY RESTRICT THE LENGTH OF TIME A MEDICAID PATIENT CAN SPEND IN THE HOSPITAL. THE LIMITS ARE NOT RELATED TO THE PATIENT'S HEALTH STATUS OR TYPE OF ILLNESS. ONE STATE, FOR EXAMPLE, LIMITS MEDICAID PAYMENT FOR INPATIENT STAYS TO 14 DAYS. THE RESULT IS THAT LEFTOVER COSTS MUST BE ABSORBED BY THE HEALTH CARE INDUSTRY AND GOVERNMENT. AND THESE COSTS ARE INCREASING DRAMATICALLY. IN 1986, HOSPITALS RECORDED $9.8 BILLION IN UNSPONSORED CARE, UP FROM $5.7 BILLION IN 1984.

NATIONALLY, 32 STATES SET THE MEDICAID ELIGIBILITY THRESHOLD AT LESS THAN HALF THE POVERTY LINE. THE RESULT: THE INELIGIBLE SEEK PRIMARY CARE IN EXPENSIVE EMERGENCY ROOM SETTINGS; THEY SEEK IT FROM A DECLINING NUMBER OF FACILITIES WHICH PROVIDE FREE OR DISCOUNTED CARE FOR THE POOR; OR THEY DON'T SEEK IT AT ALL, AND THE COST OF TREATING THEIR RESULTING ILLNESSES ARE OFTEN MUCH HIGHER THAN REGULAR, ACCESSIBLE PRIMARY CARE.

THE HEALTH POLICY AGENDA, IN ITS RECENTLY RELEASED REPORT, "INCLUDING THE POOR," PUTS FORTH EIGHT MEASURES TO REFORM MEDICAID. SUPPORT FOR THESE REFORMS IS VERY BROAD-BASED, MEASURED BY THE BREADTH OF THE COALITION THAT BACKS THEM. THE HPA COMPRISES 172 GROUPS REPRESENTING HEALTH CARE PROVIDERS, BUSINESS, LABOR, INSURERS, CONSUMERS, AND OTHER INTERESTS.

I WILL SUMMARIZE THE REFORMS:

- MEDICAID SHOULD BE RESTRUCTURED SO THAT IT IS GOVERNED BY NATIONAL STANDARDS FOR REIMBURSEMENT RATES, ELIGIBILITY RULES AND BENEFITS.

- ELIGIBILITY FOR MEDICAID SHOULD BE SET AT 100 PERCENT OF THE FEDERAL POVERTY LEVEL. CURRENTLY, MEDICAID ELIGIBILITY IS STRONGLY TIED TO ELIGIBILITY FOR OTHER CATEGORICAL PROGRAMS, NAMELY AID TO FAMILIES WITH DEPENDENT CHILDREN AND SUPPLEMENTAL SECURITY INCOME. ALMOST SEVENTY PERCENT OF MEDICAID CLIENTS QUALIFY BECAUSE THEY RECEIVE AFDC BENEFITS AND CLOSE TO 30 PERCENT BECAUSE THEY RECEIVE SSI BENEFITS. AFDC ELIGIBILITY IS SET BY EACH STATE, WHILE SSI ELIGIBILITY IS SET BY THE FEDERAL GOVERNMENT. THE HPA'S RECOMMENDED REFORM WOULD SEVER THIS LINKING OF MEDICAID TO CASH ASSISTANCE PROGRAMS.

- A STANDARD BENEFITS PACKAGE SHOULD BE FEDERALLY MANDATED FOR EVERY STATE, PROVIDING FOR BUT NOT LIMITED TO THESE BASIC SERVICES: PHYSICIAN SERVICES, INPATIENT AND OUTPATIENT HOSPITAL SERVICES, LABORATORY AND X-RAY SERVICES, PRESCRIPTION DRUGS, INSTITUTIONAL CARE OF THE ELDERLY AND THE PHYSICALLY OR MENTALLY

DISABLED, DENTAL SERVICES, PERIODIC HEALTH SCREENINGS AND DIAGNOSES, FAMILY PLANNING SERVICES, AND HOME HEALTH SERVICES.

- MEDICAID EXPANSION SHOULD INCLUDE POLICIES AND INCENTIVES TO ENCOURAGE BROADER HEALTH CARE PROVIDER PARTICIPATION.

- THE MEDICAID PROGRAM SHOULD UNDERTAKE MEASURES TO PROMOTE COST-EFFECTIVENESS. THE INCREASING BODY OF KNOWLEDGE DISCERNING THE EFFECTIVENESS OF MEDICAL PROCEDURES COULD BE BROUGHT TO BEAR ON THIS EFFORT.

- STATES SHOULD BE MANDATED TO PROVIDE HEALTH CARE SERVICES FOR THE MEDICALLY NEEDY -- THOSE WHO HAVE BECOME IMPOVERISHED DUE TO CATASTROPHIC ILLNESS BUT WHOSE INCOME LEVELS EXCEED THE MEDICAID ELIGIBILITY THRESHOLD.

- A GREATER BURDEN OF THE FISCAL IMPACT OF ELIGIBILITY EXPANSION SHOULD BE BORNE BY THE FEDERAL GOVERNMENT.

- LONG-TERM CARE SHOULD BE CONTINUED UNDER MEDICAID OR THROUGH A STRUCTURALLY IMPROVED PROGRAM.

We will now hear from our colleague, Dr. Kenneth E. Thorpe, Director, Program on Healthcare Financing and Insurance and Assistant Professor of Economics at Harvard University School of Public Health, to discuss the costs attendant to these proposals.

The analysis that has been completed assesses the coverage and cost implications of three Medicaid reform options:

- Option 1. Expansion of existing state Medicaid coverage to the uninsured with incomes below the federal poverty line.

- Option 2. Provision of a standard state benefit package at the level of existing "median" and "high" state benefit packages as described below.

- Option 3. Reimbursement of providers at market rates.

This analysis focuses on the uninsured poor under 65 years of age and was designed to identify (by state) the number of newly insured poor and the expected costs of covering these individuals that result from implementation of the above options. In addition, we estimate reductions in existing spending by the previously uninsured and reductions in cost for those who currently provide care on a pro bono basis. All cost estimates are in 1988 dollars.

1. Costs of Covering the Uninsured Poor

Extending current Medicaid benefits to the uninsured poor would cover 10.9 million individuals at a gross public cost of $9.05 billion. The southern states would account for the largest increase in new Medicaid enrollees, nearly half of the total. In contrast, the northeastern states would account for 11% of the newly eligible uninsured poor. Costs would rise from $9.05 billion to $11.7 billion if the 3.1 million newly eligible individuals with non-group plans drop their coverage in favor of the new Medicaid plan. At the extreme, if all the privately insured poor drop their plans, costs of covering all the poor would total $14.8 billion and would extend Medicaid coverage to 17.7 million individuals. Thus, gross costs of the new Medicaid plan would range from $9.05 billion to $14.8 billion, depending on decisions made by the privately insured poor to retain their existing plans.

New public expenditures would replace approximately $4.2 billion of previously uncompensated care. Of this amount, some $1.3 billion would represent direct savings over time to state and local governments through potential reductions in tax levy support of public hospitals. This reduces net new public spending for covering the uninsured poor from $9.05 billion to $7.75 billion.

98-680 O - 89 - 4

Extended Medicaid coverage would also reduce out-of-pocket spending by the previously uninsured. We estimate a reduction in such spending of approximately $2.49 billion. Net new national spending resulting from the policy would range from $2.36 billion to $8.11 billion. Thus, much of the new public expenditure would replace state and local spending for a variety of existing programs financing indigent care.

2. Costs of Mandating a Standard Medicaid Benefit Package

The incremental costs of standardizing Medicaid benefit packages, assuming each state retains its existing level of Medicaid payment to providers, have been estimated. This assumption generates high incremental cost estimates, since many states with minimal benefit packages pay providers at relatively high rates. Two benefit packages are examined, a "median"-benefit package (Washington State) and a "high"-benefit package (Minnesota). Substitution of these packages for existing Medicaid benefits would increase spending for existing Medicaid recipients as well as the newly insured. Moreover, more generous benefit packages may also increase the likelihood that the privately insured poor drop their plans in favor of the enhanced Medicaid policies.

Adopting a Washington-type plan in states with less generous benefit packages and including the uninsured poor would increase current Medicaid spending (for those under 65 years of age) from $31.2 billion to $46.8 billion. If the poor with non-group plans also switched to the enhanced Medicaid program, total program costs would increase from $31.2 billion to $49.8 billion. Finally, if all the poor enrolled in the new "Washington" plan, Medicaid costs would rise from $31.2 billion to $53.2 billion, an increase of $22 billion.

If all states adopted a Minnesota-type plan and included the uninsured poor, Medicaid spending would rise from $31.2 billion to $61.8 billion. If the poor with non-group plans also enrolled in the augmented Medicaid program, costs would increase from $31.2 billion to $66.5 billion. If all the poor enrolled, total program costs would rise from $31.2 billion to $71.6 billion.

3. Costs of Augmenting Provider Payments

Fewer than 15 state Medicaid programs reimburse physicians on a usual, customary, and reasonable basis. Most remaining states use fee schedules set at significant discounts. The large and growing gap between Medicaid reimbursement levels and physician fees has frequently

BEEN IDENTIFIED AS A MAJOR FACTOR LIMITING MEDICAID RECIPIENTS' ACCESS TO CARE. DESPITE REGIONAL VARIATION IN MEDICAID FEES, THESE PAYMENTS ARE UNIFORMLY BELOW BOTH MEDICARE AND PRIVATE PAYER REIMBURSEMENT LEVELS.

RAISING THE LEVEL OF MEDICAID PAYMENTS TO PHYSICIANS WOULD INCREASE TOTAL MEDICAID EXPENDITURES BY $1.5 BILLION. THIS INCREASE ACCOUNTS FOR A SIGNIFICANT RISE IN THE NUMBER OF OFFICE VISITS PROVIDED BY PHYSICIANS TO MEDICAID PATIENTS, AN INCREASE OF APPROXIMATELY 13.6 MILLION. THE COST OF THESE VISITS, SOME $2.3 BILLION, WOULD INCLUDE $1.79 BILLION FOR NEW VISITS AT MEDICARE RATES AND AN ADDITIONAL $544 MILLION FOR INCREASED PAYMENTS FOR EXISTING VISITS. THESE EXPENDITURES ON PHYSICIAN SERVICES WOULD BE OFFSET BY REDUCTIONS IN EXPENDITURES FOR 13.6 MILLION HOSPITAL AND CLINIC-BASED AMBULATORY VISITS. AT AN ESTIMATED AVERAGE COST OF $60 PER VISIT, MEDICAID SPENDING WOULD BE REDUCED BY $820 MILLION.

HOSPITAL OUTPATIENT DEPARTMENTS, WHICH PROVIDE THE BULK OF EXISTING AMBULATORY CARE TO MEDICAID RECIPIENTS, WOULD FACE THE LARGEST REDUCTIONS IN VISITS (APPROXIMATELY 4.9 MILLION VISITS). SIMILAR REDUCTIONS IN AMBULATORY VISITS WOULD OCCUR FOR CLINICS AND EMERGENCY DEPARTMENTS AS WELL.

FINALLY, WE ESTIMATE INCREASES IN MEDICAID EXPENDITURES RESULTING FROM RAISING HOSPITAL PAYMENTS TO THE LEVEL OF INCURRED COSTS. FOR CURRENT MEDICAID RECIPIENTS, MEDICAID HOSPITAL REVENUES ARE $2 TO $3 BILLION LOWER THAN ESTIMATED COSTS, OR APPROXIMATELY $70 TO $100 LOWER PER PATIENT DAY. WE ESTIMATE THAT AN ADDITIONAL 13.45 MILLION DAYS OF HOSPITAL CARE WOULD BE PROVIDED TO THOSE PREVIOUSLY UNINSURED, RAISING THE TOTAL SHORTFALL TO $2.9 TO $4 BILLION. THIS SHORTFALL PROVIDES OUR ESTIMATE OF THE IMPACT ON MEDICAID OF RAISING HOSPITAL PAYMENT RATES.

THESE COSTS ARE SUBSTANTIAL AND UNDERSCORE THE MAGNITUDE OF THE PROBLEMS THAT ATTEND THE MEDICAID PROGRAM AS IT IS CURRENTLY STRUCTURED. THE HPA MEDICAID REPORT BUILDS ON SUCCESSFUL INITIATIVES UNDER YOUR LEADERSHIP TO EXPAND MEDICAL COVERAGE TO GROUPS OF PEOPLE WITHIN THE TOTAL POPULATION OF THE UNINSURED POOR. WE APPLAUD THOSE EFFORTS BUT EMPHASIZE SEVERAL ADDITIONAL POINTS.

- THE POOR ARE LIKELY TO BE MORE IN NEED OF A BROADER RANGE OF SERVICES THAN OTHERS IN SOCIETY.

- THE POOR HAVE LITTLE OR NO CAPACITY TO FINANCE NON-COVERED SERVICES WITH OUT-OF-POCKET EXPENDITURES. THEREFORE, THE POOR WITH NO COVERAGE WILL RECEIVE LITTLE OR NO CARE.

- The portion of the poor population to be covered by an expanded Medicaid program is dependent upon health coverage strategies adopted for the non-poor uninsured. For example, Professor Thorpe's analysis recognizes that an employer mandate as proposed in the Congress would shift approximately half of the 11 million uninsured poor to employer -- that is, private sector -- responsibility. Furthermore, an absence of strategies to extend Medicaid coverage to the poor who have individually-purchased or group health plans would increase public sector responsibility.

Whatever the balance among these initiatives, there exists an unavoidable governmental responsibility for a large number of poor people with no coverage.

The Health Policy Agenda's Medicaid report is entitled "Including The Poor." As you approach the complex issues of responding to the deficiencies of health insurance coverage in our nation, we ask that you include the poor.

APPENDIX 1: Implementation and Cost Issues

The actual cost of the reform of the Medicaid program developed by the Health Policy Agenda depends critically on the number of newly eligible individuals enrolling. Three major uncertainties underlying our estimates concern labor supply decisions by the near poor, decisions by the poor to retain private health insurance and the potential implementation of an employer health insurance mandate. The incentives affecting these decisions (and our estimates) may be summarized as follows:

- Newly eligible individuals who purchase their own private insurance outside the workplace (i.e. non-group policy holders) have a strong incentive to drop their coverage and enroll in the expanded Medicaid program;

- Employers who predominately insure employees with incomes below the poverty line have an incentive to drop their coverage for all employees in favor of the expanded program; and

- Uninsured workers with incomes slightly above the federal poverty line have an incentive to work fewer hours, lowering their income enough to become eligible.

In each case, these incentives could result in higher costs. For instance, if all those with non-group policies enroll in the expanded Medicaid program, new Medicaid spending would rise from $9.05 billion to $11.6 billion (See Table 1). Assuming all the poor (regardless of insurance status) enroll in the program, total costs could rise to $14.8 billion.

In contrast, if implementation of an employer mandate were to accompany this proposed expansion of Medicaid, substantially lower costs would result. Adoption of legislation mandating that all firms offer health insurance to full-time workers (assuming, for instance, enactment of the Kennedy-Waxman employer mandate introduced in the 100th Congress) would extend coverage to approximately 23-24 million individuals. Of this total, 5.6 million newly mandated workers and dependents live in families with incomes below the federal poverty line (See Table 2). Health care costs for these low-income workers and their dependents would be covered through workplace plans, leaving approximately 5.3 million individuals eligible for an expanded Medicaid program. In this case, new Medicaid spending would total $5 billion (approximately $2.8 billion in new federal spending and $2.2 billion in state and local expenditures).

TABLE 1:

NUMBER OF RECIPIENTS AND COSTS
WITH ELIGIBILITY AT 100% OF POVERTY

ORIGINAL STATE BENEFIT PACKAGES

	MEDICAID		UNINSURED		NON-GROUP PRIVATELY INS.		GROUP PRIVATELY INS.		TOTAL	
REGION	NUMBER [1]	COST[2]	NUMBER	COST	NUMBER	COST	NUMBER	COST	NUMBER	COST
NEW ENGLAND	0.6	$2,078	0.2	$ 223	0.1	$ 119	0.1	$ 132	1.1	$ 2,552
MID ATLANTIC	2.7	7,429	1.0	1,144	0.2	268	0.4	405	4.3	11,798
E. N. CENTRAL	3.2	6,361	1.3	1,346	0.5	466	0.7	686	5.6	8,859
W.N. CENTRAL	1.1	1,846	0.6	463	0.4	398	0.3	221	2.4	2,928
SOUTH ATLANTIC	2.0	3,599	1.9	1,314	0.5	359	0.7	496	5.0	5,768
E.S. CENTRAL	1.1	1,561	1.3	896	0.2	150	0.3	194	2.9	2,801
W.S. CENTRAL	1.4	2,527	2.2	1,810	0.4	341	0.5	397	4.5	5,075
MOUNTAIN	0.5	729	0.8	459	0.3	207	0.3	141	1.9	1,536
PACIFIC	2.8	5,100	1.6	1,400	0.5	330	0.5	418	5.5	7,248
TOTAL	15.5	$31,230	10.9	9,054	3.1	2,639	3.7	3,089	33.2	46,012

1. Current enrollment, from CPS 1987 count of Medicaid recipients under age 65. Includes all recipients under federal poverty standard.

2. All costs are in millions. Current Medicaid spending includes expenditures for all recipients under age 65, from 2082 (1986), adjusted to 1988 dollars, and projected costs for coverage of pregnant women and infants recently adopted. HCFA figure is $25 billion in 1986 dollars. Differential for new legislation is $1.2 billion and assumes 100% of eligible uninsured in Medicaid.

TABLE 2:

Coverage and Public Costs of Medicaid Expansion After Employer Mandate
(in Millions of people and billions of 1988 dollars)

PERCENT OF FEDERAL POVERTY LINE	PREVIOUSLY UNINSURED MANDATED	PREVIOUSLY UNINSURED NOT MANDATED	NEW MEDICAID PROGRAM COSTS[a]	NEW MEDICAID PROGRAM COSTS[b]
0 - 100	5.6	5.3	$ 5.0	$ 6.6
101 - 200	7.6	3.4	0	0
201 and above	11.4	4.0	0	0
TOTALS	24.6	12.7	$ 5.0	$ 6.6

a. Includes costs only for previously uninsured enrolling in new program. Federal share estimated at approximately $2.8 billion, state and local $2.2 billion. We assume implementation of a Kennedy-Waxman type mandate (S.1265 from 100th Congress).

b. Assumes all those below poverty line with non-group policies, not mandated would enroll in the program.

Original Contributions

Including the Poor: The Fiscal Impacts of Medicaid Expansion

Kenneth E. Thorpe, PhD; Joanna E. Siegel, RN, SM; Theresa Dailey

This article presents the fiscal impacts of the comprehensive reform of the Medicaid program put forth by the Health Policy Agenda for the American People. Proposed reforms include establishment of improved uniform eligibility standards, improvement in the scope and depth of coverage in state Medicaid programs, and increased provider payment rates. We estimate that expanding Medicaid coverage to all currently uninsured nonelderly persons below the federal poverty line would cost approximately $9 billion. A substantial portion of these costs would offset current spending elsewhere in the health care system. Improvement of state packages and increased provider payment could result in sharp increases in costs. We provide a range of estimates considering both the set of benefits provided and the behavior of the private insurance market.

(*JAMA*. 1989;261:1003-1007)

OF THE estimated 37 million Americans who lack health insurance coverage, over 10.9 million are poor.[1] Recent changes in the private insurance market, including reductions in employer-sponsored health policies and limited availability of dependent coverage,[2] have contributed to the large and growing number of uninsured. Lack of insurance among the poor, however, has been exacerbated by a long-term decline in the proportion of the poor covered by Medicaid.

For editorial comment, see p 1044.

Although Medicaid was designed to provide access to medical care for low-income individuals, it currently covers less than half the poverty population.[3] Because Medicaid programs are linked to cash assistance programs with varying eligibility levels, the eligible proportion of the poverty population ranges across states from 17% to 83% of the poor.[4] Even when Medicaid is available, the range of benefits often is inadequate. Although the program mandates certain basic services, states have wide latitude in adding optional services and limiting access even to basic services. Eleven states limit the number of covered hospital days, while another 11 limit the number of hospital outpatient visits during a year.[5] Provider reimbursement levels under Medicaid are low and often limit access to care. Most notably, payments for physician office visits may be less than half the amount paid by Medicare and private payers. These shortcomings in the Medicaid program, combined with the chronically uninsured state of many of the poor, have again brought Medicaid reform to the policy forefront.

This article presents the fiscal impacts of a proposal for the comprehensive reform of the Medicaid program put forth by the Health Policy Agenda for the American People. The Health Policy Agenda for the American People, a coalition of 172 public and private sector organizations,[6] identified Medicaid reform as one of the nation's most urgent health care issues. Their Ad Hoc Committee on Medicaid developed specific recommendations focused on improved eligibility, uniformity, and effectiveness of the Medicaid program.[7] These recommendations include the following:

- Breaking the categorical eligibility link between public assistance programs and Medicaid eligibility. A simple income standard, set at the federal poverty level, would determine eligibility for health benefits. Enrolling all the uninsured poor would serve as the goal of this reform.
- The development of a standard benefit package including, at a minimum, physician services; inpatient and outpatient hospital services; laboratory and x-ray services; institutional care for the elderly and the physically or mentally disabled; early periodic screening, diagnosis, and treatment; family planning services; home and personal care; and dental services. Existing state restrictions on use of these services would be eliminated.
- Reform should include incentives to encourage broader participation by health care providers. As a first step, providers should be reimbursed at Medicare payment levels and hospitals at cost.

Recent federal legislation affecting pregnant women and children has weakened Medicaid's traditional link to the Aid to Families With Dependent Children and other state welfare programs. For example, Medicare's catastrophic insurance package mandates coverage, by 1990, of all pregnant wom-

From the Department of Health Policy and Management, School of Public Health, Harvard University, Boston, Mass.

Reprint requests to the Department of Health Policy and Management, Harvard University School of Public Health, 677 Huntington Ave, Boston, MA 02115 (Dr Thorpe).

en and infants under the poverty level. Implementation of the reforms proposed by the Health Policy Agenda for the American People would expand this trend, extending coverage to all the uninsured poor. As a result, millions of individuals would receive health insurance and improved access to health care.

METHODS

Our analysis assesses the coverage and cost implications of three Medicaid reform options:

- Option 1. Expansion of existing state Medicaid coverage to the uninsured with incomes below the federal poverty line.
- Option 2. Provision of a standard state benefit package at the level of existing "median" and "high" state benefit packages (described below).
- Option 3. Reimbursement of providers at market rates.

Our analysis was designed to identify (by state) the number of newly insured poor and the expected costs of covering these individuals that result from implementation of the above options. Our analysis focuses on the uninsured poor under 65 years of age. In addition, we estimate reductions in existing spending by the previously uninsured and reductions in cost for those who currently provide care on a pro bono basis. The methods used to estimate increased public expenditures are described below. A more detailed explanation is provided elsewhere.[9] All cost estimates are in 1988 dollars.

New public costs traced to the policy options described above were determined sequentially. First, we calculated the costs of extending coverage to the uninsured poor, holding constant every state's existing benefit package and reimbursement policies. These expected new costs are based on state-level counts of the uninsured poor, by age and sex, calculated from the March 1987 Current Population Survey. The Current Population Survey may overcount the uninsured, particularly in some population groups, resulting in higher cost estimates. However, this data set contains recent data and has a larger sample size than similar surveys, making it a useful source for national estimates.[10]

Age-specific costs of coverage for the uninsured are based on data from the Health Care Financing Administration Form 2082, which documents Medicaid costs per recipient. For the 24 states where data are available, we calculate Medicaid expenditures per Aid to Families With Dependent Children cash recipient in several age groupings. Ratios of Medicaid spending for each age category to the overall average are aggregated within each of nine census divisions. These ratios are then applied to state Medicaid data where age adjustments are not directly possible, to obtain estimates of age-specific costs per recipient. The resulting state- and age-specific costs are used to calculate total costs of insuring the uninsured poor in each state. Since most states have already implemented coverage for poor pregnant women and infants,[10] we exclude estimated cost of this coverage from incremental costs. Instead, these costs are included in the baseline estimates of Medicaid expenditures.

Studies on Medicaid and other insured groups indicate that on average about 13% of enrollees seek no services during a given year.[11,12] Use of recipient data may therefore increase our incremental cost estimates by a corresponding percentage. Thus, we believe they represent upper bounds.

To estimate the expected cost of providing an acceptable uniform benefit package across states, we selected two existing state Medicaid programs. Based on a ranking of both the breadth and scope of services, we selected Minnesota's plan, a relatively "high"-benefit plan, and Washington State's, a "median" plan. Minnesota's plan provides the second-largest number of optional services (30) and few limits on basic medical services.[4,13] The service package in Washington represented a solid but not extremely generous Medicaid program. In contrast to Minnesota's, Washington's service package limits access to physician services and home health services. However, Washington provides relatively good drug coverage and well-child care services.

Having selected these plans, we estimated the additional costs of implementing them in each state. By definition, implementing the Minnesota plan should increase costs in nearly all states, with cost increases resulting from the Washington plan limited to approximately 20 to 25 states. Expected costs were calculated by applying Minnesota's and Washington's age-adjusted per-recipient costs to each state, holding constant existing payment levels in all states and adjusting for cost-of-living differences.

Finally, the impact of increasing reimbursement levels for physicians (to Medicare levels) and hospitals (to incurred costs) were calculated. Estimated increases in physician fees are based on inflation-adjusted Medicaid payment rates for a standard physician office visit. Such visits represent approximately 30% of Medicaid physician spending, by far the largest single expenditure item (Massachusetts Medicaid Office, unpublished data, July 1987). Average payment rates are estimated within each of four census regions. These averages, ranging from $15 to $25 per visit, are increased to Medicare payment levels (Table 1).

Table 1.—Medicaid Payment Rates for an Established Office Visit as a Percentage of Medicare and Private Payers*

Census Region	% of Medicare	% of Private Payers
Northeast	53	45
North Central	72	58
South	69	53
West	68	52

*Authors' calculations were based on data from the American Medical Association Socioeconomic Monitoring Service and on results presented in reference 13.

Medicaid expenditures will also be affected by changes in the volume of physician services resulting from fee increases. Changes in the number of physician and other ambulatory-care visits are estimated using results from two recent empirical studies.[14,15] These studies demonstrate that (1) a 10% rise in Medicaid payments results in a 2% to 3% rise in the probability of seeing a physician, and (2) increases in the number of physician visits have been accompanied by corresponding reductions in other types of ambulatory care. Thus, the literature suggests that increasing Medicaid fee levels to Medicare rates will shift the site where patients receive care, but leave the total volume of ambulatory care essentially unchanged. Our estimate of the impact of increasing physician payment considers both effects.

The projected effect of raising average Medicaid hospital payments is based on a calculation of the existing Medicaid hospital payment shortfall per patient day, derived from gross state-level data from the American Hospital Association 1987 Annual Survey of Hospitals.[16] This per-day shortfall is multiplied by the expected number of new Medicaid hospital days under an expanded Medicaid program. This figure is derived from hospital days per current Medicaid recipient in each state for two age groups, those under 19 years of age and all others.[12,17]

One major source of uncertainty regarding the public costs of the options described above is how many individuals would enroll. Since the policy objective is to extend coverage to all currently uninsured poor, we assume complete participation by this group. Lower rates of enrollment would, of course,

Table 2.—Costs and Number (in Millions) of New Eligibles Under Expanded Medicaid Eligibility, by Current Insurance Status*

	Uninsured		Nongroup Privately Insured		Group Privately Insured		Total	
Census Region	No.	Cost, $	No.	Cost, $	No.	Cost, $	No.	Cost, $
Northeast	1.2	1367	0.3	387	0.5	537	2.0	2291
North Central	1.9	1809	0.9	864	1.0	1403	3.8	4076
South	5.4	4020	1.1	650	1.5	791	8.0	5461
West	2.4	1859	0.8	537	0.8	559	4.0	2955
Total United States	10.9	9055	3.1	2638	3.7	3090	17.7	14783

*Authors' calculations were based on the 1987 Current Population Survey and the 1986 Health Care Financing Administration Form 2082 data.

result in lower costs. More problematic is the number of privately insured poor who would switch from their existing plans to the new public insurance program. To account for this possibility, we divide the insured poor into two groups: those purchasing nongroup (individually purchased) policies and those with group (generally employment-based) health insurance. We then estimate the additional public costs by alternatively assuming that only those with nongroup policies switch, a highly probable scenario, and then that all those with private insurance switch, clearly an upper estimate.

We do not include specific estimates of any potential work disincentives the Medicaid expansion may have on those with incomes above the poverty line, or assessments of programs that address such disincentives, such as buy-in provisions. In addition, we do not examine the effect of legislation mandating employer-based coverage, targeted at the working uninsured. As 5.3 of the 10.9 million uninsured poor live in families with at least one employed person, an employer mandate would have a major impact on the cost of the proposed Medicaid reforms. These issues are treated in detail elsewhere (K.E.T. and J.E.S., unpublished data, December 1988).

Some of the new public expenditures described above would replace existing spending in the system. For instance, the uninsured currently pay out-of-pocket for some medical care and often receive care in-kind (ie, uncompensated care). Most out-of-pocket spending and a substantial portion of uncompensated care would be removed through a Medicaid expansion. The American Hospital Association identifies close to $9.8 billion in uncompensated hospital costs. The uninsured poor account for 40% to 50% of this total.[14] Using state-level data, estimated reductions in uncompensated care following coverage of the uninsured poor were calculated. For each state with a public hospital system, 32% of these savings were apportioned to the public sector, with remaining savings allocated to the private sector.[15]

Reductions in out-of-pocket spending for the previously uninsured poor are calculated using data from the National Medical Care Utilization and Expenditure Survey.[16] The offset figure represents the difference between out-of-pocket expenditures by the uninsured compared with the insured. Using these data, a Medicaid expansion to the federal poverty line would replace an estimated $2.49 billion in out-of-pocket spending by the uninsured poor.

RESULTS

Option 1. Covering the Uninsured Poor

Extending current Medicaid benefits to the uninsured poor would cover 10.9 million individuals at a gross public cost of $9.05 billion (Table 2). The southern states would account for the largest increase in new Medicaid enrollees, nearly half of the total. In contrast, the northeastern states would account for 11% of the newly eligible uninsured poor. Costs would rise from $9.05 billion to $11.7 billion if the 3.1 million newly eligible individuals with nongroup plans drop their coverage in favor of the new Medicaid plan. At the extreme, if all the privately insured poor drop their plans, costs of covering all the poor would total $14.8 billion and would extend Medicaid coverage to 17.7 million individuals. Thus, gross costs of the new Medicaid plan would range from $9.05 billion to $14.8 billion, depending on decisions made by the privately insured poor to retain their existing plans.

New public expenditures would replace approximately $4.2 billion of previously uncompensated care. Of this amount, some $1.3 billion would represent direct savings over time to state and local governments through potential reductions in tax levy support of public hospitals. This reduces net new public spending for covering the uninsured poor from $9.05 billion to $7.75 billion.

Extended Medicaid coverage would also reduce out-of-pocket spending by the previously uninsured. We estimate a reduction in such spending of approximately $2.49 billion. Net new national spending resulting from the policy would range from $2.36 billion to $8.11 billion. Thus, much of the new public expenditure would replace state and local spending for a variety of existing programs financing indigent care.

Option 2. Mandating a Standard Medicaid Benefit Package

The results presented below estimate the incremental costs of standardizing Medicaid benefit packages, assuming each state retains its existing level of Medicaid payment to providers. This assumption generates high incremental cost estimates, since many states with minimal benefit packages pay providers at relatively high rates. Two benefit packages are examined, a "median"-benefit package (Washington State) and a "high"-benefit package (Minnesota). Substitution of these packages for existing Medicaid benefits would increase spending for existing Medicaid recipients as well as the newly insured. Moreover, more generous benefit packages may also increase the likelihood that the privately insured poor drop their plans in favor of the enhanced Medicaid policies.

Adopting a Washington-type plan in states with less generous benefit packages and including the uninsured poor would increase current Medicaid spending (for those under 65 years of age) from $31.2 billion to $46.8 billion (Table 3). If the poor with nongroup plans also switched to the enhanced Medicaid program, total program costs would increase from $31.2 billion to $49.8 billion. Finally, if all the poor enrolled in the new "Washington" plan, Medicaid costs would rise from $31.2 billion to $53.2 billion, an increase of $22 billion.

If all states adopted a Minnesota-type plan and included the uninsured poor, Medicaid spending would rise from $31.2 billion to $61.8 billion. If the poor with nongroup plans also enrolled in the augmented Medicaid program, costs would increase from $31.2 billion to $66.5 billion. If all the poor enrolled, total program costs would rise from $31.2 billion to $71.6 billion.

Option 3. Augmenting Provider Payments

Fewer than 15 state Medicaid programs reimburse physicians on a usual, customary, and reasonable basis.[4] Most remaining states use fee schedules set at significant discounts. The large and growing gap between Medicaid reim-

Table 3.—Medicaid Expenditures (in Millions of Dollars) With Eligibility at 100% of Poverty Standard: Original and Improved State Benefit Packages*

Region	Current Medicaid†	Uninsured	Nongroup Privately Insured	Group Privately Insured	Total
		Original State Benefit Package			
Northeast	9507	1367	387	537	11 796
North Central	8207	1809	864	907	11 786
South	7687	4020	850	1087	13 645
West	5829	1859	537	559	8784
Total	31 230	9055	2638	3090	46 013
		Improved State Package: Washington Model			
Northeast	9529	1369	390	540	11 828
North Central	9992	1913	908	955	13 769
South	9403	4748	1022	1274	16 447
West	7518	2334	636	691	11 179
Total	36 443	10 363	2957	3460	53 223
		Improved State Package: Minnesota Model			
Northeast	10 627	1588	505	639	13 359
North Central	11 641	2737	1313	1322	17 013
South	12 714	7347	1724	1995	23 780
West	11 307	3881	1091	1173	17 452
Total	46 289	15 553	4634	5128	71 604

*Authors' calculations were based on the 1987 Current Population Survey and the 1986 Health Care Financing Administration Form 2082 data.
†Represents Medicaid expenditures (in 1988 dollars) for recipients under the age of 65 years.

Table 4.—Estimated Annual No. of Ambulatory Care Visits (in Millions) by Site of Care and Census Region, Before and After Raising Medicaid Fee Levels*

Region	Before Fee Increase	After Fee Increase	Change in No. of Visits
Northeast			
Physicians' office	14.00	17.60	3.60
Outpatient department	3.78	2.56	−1.22
Emergency department	6.21	5.67	−0.54
Clinic	2.97	1.16	−1.81
North Central			
Physicians' office	21.40	24.30	2.90
Outpatient department	4.58	3.53	−1.05
Emergency department	8.33	7.81	−0.52
Clinic	2.86	1.60	−1.26
South			
Physicians' office	34.20	38.73	4.53
Outpatient department	7.31	5.65	−1.66
Emergency department	13.30	12.50	−0.80
Clinic	4.36	2.56	−1.80
West			
Physicians' office	19.70	22.30	2.60
Outpatient department	4.21	3.25	−0.96
Emergency department	7.66	7.18	−0.48
Clinic	2.63	1.47	−1.16

*Authors' calculations were derived from Congressional Research Service analysis of 1986 Health Interview Survey public use tapes.

bursement levels and physician fees has frequently been identified as a major factor limiting Medicaid recipients' access to care. Despite regional variation in Medicaid fees, these payments are uniformly below both Medicare and private payer reimbursement levels.

Raising the level of Medicaid payments to physicians would increase total Medicaid expenditures by $1.5 billion. This increase accounts for a significant rise in the number of office visits provided by physicians to Medicaid patients, an increase of approximately 13.6 million (Table 4). The cost of these visits, some $2.3 billion, would include $1.79 billion for new visits at Medicare rates and an additional $544 million for increased payments for existing visits. These expenditures on physician services would be offset by reductions in expenditures for 13.6 million hospital- and clinic-based ambulatory visits. At an estimated average cost of $60 per visit (Massachusetts Medicaid Office, unpublished data, July 1987),[18] Medicaid spending would be reduced by $820 million. Hospital outpatient departments, which provide the bulk of existing ambulatory care to Medicaid recipients, would face the largest reductions in visits (approximately 4.9 million visits). Similar reductions in ambulatory visits would occur for clinics and emergency departments as well (Table 4).

Finally we estimate increases in Medicaid expenditures resulting from raising hospital payments to the level of incurred costs. For current Medicaid recipients, Medicaid hospital revenues are $2 to $3 billion lower than estimated costs, or approximately $70 to $100 lower per patient day. We estimate that an additional 13.45 million days of hospital care would be provided to those previously uninsured, raising the total shortfall to $2.9 to $4 billion. This shortfall provides our estimate of the impact on Medicaid of raising hospital payment rates.

COMMENT

Expanding Medicaid coverage to all currently uninsured persons below the federal poverty line would cost approximately $9 billion. Of this total, $5 billion would represent new federal outlays, with the remainder absorbed by state and local governments. A substantial portion of these increased Medicaid expenditures would offset current spending elsewhere in the health care system. Expansion of Medicaid would reduce utilization of federal programs serving the poor uninsured, for example, Veterans Administration hospital services. The magnitude of expected reductions in expenditures for these programs is unclear. Current spending by state and local governments would also fall. State and local government tax levy support for public hospitals would be reduced at least $1.4 billion. In addition, states would save a significant portion of the estimated $3 billion currently spent on programs for the medically indigent.[21] Limited data on the scope and spending of these programs make precise estimates of potential savings difficult. The combined reductions in state and local tax levy support, plus even a modest reduction in spending for state-financed programs for the indigent, would limit net new state and local spending to under $2 billion in exchange for extending coverage to 10.9 million previously uninsured poor.

Covering all uninsured below the poverty line would also reduce existing out-of-pocket spending by the poor on health care. An extension of Medicaid to those living in poverty would represent a cash transfer (ie, savings through re-

duced out-of-pocket spending) of nearly $2.5 billion to this group.

Depending on the set of benefits selected, increasing the breadth and depth of existing coverage could increase spending sharply. Implementation of a median state benefit package (along the lines of the Washington State program) would increase Medicaid spending by $19 billion, assuming the expanded program covered the uninsured and nongroup privately insured. Use of a prototype benefit package similar to Minnesota's would result in an even larger increment in spending for the same population, over $35 billion (Table 3). Finally, if states reimbursed physicians at Medicare levels and hospitals at incurred costs, costs would rise an additional $4.4 to $5.5 billion.

A number of factors are likely to influence these cost and coverage estimates. Use of Current Population Survey counts of the uninsured and recipient cost data may have inflated our estimates. In addition, the estimates presented herein do not consider a number of critical implementation issues. For example, a spend-down provision allowing for coverage of the nonpoor who incur large medical expenditures would be expected to increase Medicaid expenditures. Inclusion of a buy-in provision, allowing the near-poor to purchase Medicaid coverage at subsidized rates, would lower costs of insuring the uninsured poor by reducing work disincentives. Total program costs could increase dramatically, however, due to the subsidization of nonpoor participants. In contrast, an employer mandate to provide insurance would extend private coverage to a large proportion of the uninsured poor, significantly decreasing the costs of expanding Medicaid eligibility. In the final analysis, the public sector impact of Medicaid expansion and other programs designed to address the problems of the uninsured poor will depend greatly on their effects on the nonpoor uninsured and the private insurance market.

This research was supported by the Health Policy Agenda for the American People.

We thank the members of the Ad Hoc Committee on Medicaid for providing their expertise and comments. Special thanks are owed James R. Tallon, Jr, MA, and Elisabeth G. Houston, MS.

References

1. *Current Population Survey*. US Dept of Commerce; March 1987.
2. *Health Insurance and the Uninsured: Background Data and Analysis*. Washington, DC: Congressional Research Service; 1988:94-121.
3. *A Children's Defense Budget*. Washington, DC: Children's Defense Fund; 1988.
4. *Medicare and Medicaid Data Book*, publication 03247. Health Care Financing Administration; 1986.
5. US Dept of Health and Human Services. *Health Care Financing Program Statistics: Analysis of State Medicaid Program Characteristics, 1986*. Baltimore, Md: Office of the Actuary, Health Care Financing Administration; August 1987.
6. Health Policy Agenda Steering Committee. Health policy agenda for the American people. *JAMA*. 1987;257:1199-1210.
7. *Including the Poor: The Final Report of the Ad Hoc Committee on Medicaid*. Chicago, Ill: Health Policy Agenda for the American People; November 1989.
8. Thorpe K, Siegel J, Dailey T. *Costs of Extending Medicaid to the Uninsured Poor*. Boston, Mass: Harvard School of Public Health; 1988.
9. Newacheck PA. *Estimating Medicaid-Eligible Pregnant Women and Children Living Below 185% of Poverty*. Washington, DC: National Governor's Association; 1988.
10. *Campaign Notes*. Washington, DC: Children's Defense Fund; November 1988.
11. Manning WG, Newhouse JP, Duan N, Keeler EB, Liebowitz A, Marquis MS. Health insurance and the demand for medical care: evidence from a randomized experiment. *Am Econom Rev*. 1987; 77(2):251-277.
12. Howell EM, Rymer MP, Baugh DK. Medicaid tape-to-tape findings: California, New York, and Michigan, 1981. *Health Care Financ Rev*. 1988;9(4):1-30.
13. *Medicaid Services by State*, Health Care Financing Administration publication 02153-86. US Dept of Health and Human Services; October 1987.
14. Gold M. The demand for hospital outpatient services. *Health Services Res*. 1984;3:383-412.
15. Long S, Settle R, Stuart B. Reimbursement and access to physicians' services under Medicaid. *J Health Econom*. 1986;5:235-252.
16. *Annual Survey of Hospitals*. Chicago, Ill: American Hospital Association; 1987.
17. *Form 2082 Data Set*. Health Care Financing Administration; 1986.
18. Duncan P, Colbert J, Pendergrast J. *State University Study of Indigent Care: The Analytic Report*. Gainesville, Fla: Center for Health Policy Research, University of Florida Health Center; 1986:2.
19. *Public Hospitals: Sales Lead to Better Facilities but Increased Patient Costs*. US General Accounting Office; 1986: Appendix IX.
20. *National Medical Care Utilization and Expenditure Survey*. Health Care Financing Administration; 1980.
21. Desonia RA, King KM. *State Programs of Assistance to the Medically Indigent*. Baltimore, Md: Office of Research and Demonstration; 1988.

Mr. WAXMAN. Thank you very much, Mr. Tallon and Mr. Thorpe. Dr. Kronick.

STATEMENT OF RICHARD KRONICK

Mr. KRONICK. Thank you, Mr. Chairman. My name is Richard Kronick. I am a policy analyst in the Department of Community and Family Medicine of the University of California at San Diego. Thank you for the opportunity to testify this morning. I would like to briefly highlight a plan for achieving universal health insurance that I worked on last year with Allan Entoven, who is a health economist at Stanford University. The plan was published in the New England Journal of Medicine, and the details are available there.

Before the beginning, let me just mention that it is not just simply the work of ivory towered academics. Before moving to California, I worked for 4 years in Massachusetts State government, and I'm aware of the possibilities and strengths and weaknesses of State government. We have designed this plan with those considerations in mind.

We propose a plan to achieve universal health insurance in a system designed to promote quality and economy in health care delivery system. We are looking at both problems that we have heard discussed at length this morning, 37 million people uninsured, not enough resources for them and too many resources for many of the rest of us.

Our plan has four key elements. First, a mandate that employers provide coverage to fulltime employees. This looks much like the mandate that was in the bill that Congressman Waxman and Senator Kennedy introduced last year.

Second, the creation of State level public sponsor agencies that would function much like large employers for people who aren't going to be covered by the employer mandate. These are agencies that would contract with health plans, manage and enrollment process and administer subsidies. Basically these are the jobs that large employers do, and they are already in most States agencies that do this for State employees.

What we have in mind for public sponsors are agencies that would carry out much of the same functions for people who are not employed fulltime; that is, for part-time employed people, for self-employed people, for the unemployed, for widows and divorcees, et cetera.

The third component of our plan is a limitation on the amount of tax free employer contribution to health insurance. The fourth component is a pay or play tax on the earnings of part-time workers and on the earnings of self- employed people.

Let me talk a little bit more about the public sponsor and then discuss the other points. Employers would be required to pay for 80 percent of the health benefits of their health workers. The public sponsor would do the same thing for people who are not employed, self-employed or part-time employee. Someone who is not covered by their employer could go to the State agency. The State agency would have contracts with health plans just the way employers would.

The agencies would say here, pick among this menu of health plans. We will pay 80 percent and you pay the difference between the 80 percent and the cost of the health plan. For the very poorest, there would be another subsidy so that even much of that difference would be covered.

The tax cap—we propose limiting the amount of tax-free employer contributions. Right now, everything that our employers contribute to us is just tax free. We propose limiting that amount of tax-free contribution to the 80 percent that employers would be required to provide. Employers have to pay for 80 percent, 80 percent will be tax-free. Anything above that would be taxable.

There are two important reasons for this proposal. One is to raise money. The Congressional Budget Office estimates that this would raise about $11 billion, and that's an important part of the financing for the public sponsors here. Those of us who are going to pay the extra $11 billion clearly are not going to like that or many of us will not. I do think there are very strong equity arguments for it.

I think that Medicare and Medicaid are the two largest government health expenditure programs—not true. The second largest is not Medicaid, but the tax expenditure to support our health benefits, which is at least $40 and probably closer to $50 billion expenditure. Those are moneys spent for middle and upper middle class people primarily, and there's a very strong equity argument to take some of that $10 or $11 billion and move it on behalf of some of the 37 million people who don't have health insurance now.

One reason is to raise money. The second reason for the tax cap is to try to create an environment in which physicians and hospitals see it as their job to deliver quality care economically. It is clearly not the environment we are in today. The Commission for National Leadership made some good suggestions this morning about new information needed to change the behavior of physicians and hospitals.

In addition to new information, I think that the financial situation in which providers work needs to be changed. To do that, those of us choosing health plans need to face the cost consequences of it.

If my employer gives me a choice of three health plans and pays 80 percent of the average, if I choose the most expensive I should have to pay for it. As long as the tax laws allow us to shelter employer contribution to health benefits, that isn't going to happen.

Thank you, Mr. Chairman.

[Testimony resumes on p. 126.]

[The prepared statement of Mr. Kronick follows:]

Richard Kronick

Department of Community and Family Medicine
University of California, San Diego

My name is Richard Kronick. I am a health policy analyst in the Department of Community and Family Medicine at the University of California, San Diego. This morning I will cover the highlights of a plan to achieve universal health insurance that I designed last year with Alain Enthoven, who is a health economist at Stanford University. This plan was published in the New England Journal of Medicine on January 5 and January 12, and details are available there.

Let me mention at the start that this plan is not the work of fuzzy-headed academics: before moving to California I spent four years in Massachusetts state government -- two years working on policy initiatives increasing access to care, including the early stages of the 'Health Care for All' legislation that was passed last spring, and two years in the Medicaid program managing policy and reimbursement activities. So I have a strong sense of the realities of the political process (or at least one of them) and of the operational strengths and weaknesses of state governement. The proposal I will describe today has been designed with these considerations in mind.

Our health care economy is a paradox of excess and deprivation. We spend about 11.5% of our gross national product on health care, much more than any other country. And where other countries have stabilized the share of their GNP that is spent on health, ours has accelerated in recent years. These growing expenditures are adding greatly to deficits in the public sector, threatening the solvency of some industrial companies, and creating heavy burdens for many people.

At the same time, roughly 35 million Americans have no financial protection from the expenses of medical care. Our present system of financing health care systematically denies coverage to many who need it

most. Health insurers want to insure those who are the least likely to need medical care and to protect themselves and their policy holders from the costs associated with the care of the very sick.

The present system of financing health care in the United States is unfair. It provides most people -- those who are regularly employed by a medium sized or large employer -- with coverage either at no cost or at prices subsidized by the employer and the tax system. But the system denies the opportunity of coverage to millions of others for no good reason -- to seasonal and part-time employees, self-employed persons, widows, divorcees, early retirees, the unemployed, and others whose employers choose not to provide health care coverage. Viewed another way, when the uninsured are seriously ill (and most expenses are for seriously ill patients), taxpayers, insured persons, or both end up paying for most of their care. Voluntarily or involuntarily, some people are taking a free ride. Those who can do so ought to contribute their fair share to their coverage and be insured.

The present system is wasteful in many repsects. We have spent little on evaluating medical technology, and there is much uncertainty about its efficacy. Much care appears to be of unproved value. There is considerable duplication and excess capacity in our medical facilities.

The U.S. health care economy is inflationary. It is still dominated by fee-for-service payment of doctors and hospitals by third-party intermediaries with open-ended sources of finance. There is no total budget set in advance within which providers must manage the care of their patients. For the most part, there is no incentive to find and use medical practices that produce the same health outcome at less cost.

And this method of payment leaves insured consumers largely unaware of the costs of the services they receive.

Health maintenance organizations and preferred provider organizations now cover more than 60 million Americans. Such plans have the potential to create serious cost consciousness among consumers and providers. But they will not achieve it as long as potential subscribers do not have to pay the full extra cost themselves when they choose a more costly plan.

The employers of most insured people offer their employees a traditional insurance scheme by which all or most of their medical expenses are reimbursed after the payment of a deductible. If employers offer a less costly managed care plan, they often offer to pay its premium in full, as long as it does not exceed that of the traditional plan. Thus, the managed care plan has little or no incentive to reduce its price or improve its efficiency, because the employee making the choice sees lttle or no financial reward for choosing it.

Some employers offer a fixed-dollar contribution and a cost-conscious choice of plan. In such cases, the managed care plan is motivated to reduce its price to attract subscribers. But even then, the Internal Revenue Code permits employees to characterize their premium contributions as nontaxable employer contributions and thus make the payment with pretax dollars. The effect is that if an employee chooses a health plan that is more rather than less costly, the government is likely to be paying about one-third of the difference in cost in the form of tax relief. As a result, the employee's cost consciousness is attenuated, and the health plan has less need to cut its price to attract subscribers. In any case, health plans have little

or no incentive to improve their efficiency in order to serve a few cost-conscious customers if most of their customers are not cost conscious; such plans need only shift costs from the former to the latter.

Moreover, most such 'managed care' plans are really little more than traditional insurance arrangements that deal with physicians on an arms-length basis. It is unlikely that they will be able to achieve economical organization and delivery of care without obtaining the support of physicians and their commitment to that goal.

For all these reasons, our present system of health care does not reflect American values. We cherish efficiency and fairness, but we have a system that is neither efficient nor fair. Very few Americans believe that other Americans should be deprived of needed care or subjected to extreme financial hardship because of an inability to pay. There is widespread public outrage when a hospital turns away a delivering mother or an injured person for this reason. Congress has passed laws to punish hopsitals that do this. But we have failed as a society to create institutions that assure all persons of the opportunity to obtain needed care, when they need it and without an excessive financial burden.

Although some might disagree on the particulars of this indictment, most would agree with the general outline. We use too many resources for the medical care of some, and not enough for the medical care of others. What should we do about it?

A Universal Health Insurance Plan Based on Managed Competition with Mixed Public and Private Sponsorship

We propose a plan to achieve universal health insurance in a system designed to promote quality and economy that has four key elements:

first, a mandate that employers provide coverage to full time employees;

second, the creation of state-level public sponsor agencies that would function much like the health benefits operation of a large employer (that is, contract with health plans, manage an enrollment process, administer subsidies, and more generally manage competition among health plans) on behalf of people not included in the employer mandate -- e.g., the self-employed, the part-time employed, the unemployed. In addition, the public sponsor would function as a health insurance broker for small and medium sized businesses, giving them access to the advantages of 'managed competition' and large group purchasing power.

third, a limitation on the amount of tax free employer contribution to health insurance;

fourth, a 'pay or play' tax on the earnings of part-time workers. Employers could choose to provide health benefits to part-time workers; if they choose not to, as we suspect most would, the employer would pay a tax on their earnings.

In addition to these four key elements there are two special subsidies -- first, for the poor, and second, for small businesses -- that are an important part of the plan and which I will describe after first amplifying on the four key elements.

The first element -- an employer mandate -- is a concept I know you are familiar with. We endorse a proposal very similar to that proposed in the last session in a bill introduced by Senator Kennedy and Congressman Waxman. Employers would be required to offer their employees a choice of 'qualified' health plans. Employers would be required to pay 80% of the cost of the average qualified health plan for employees and their dependents. Employees could not waive coverage for themselves, and could waive coverage for dependents only if the dependents were covered by their spouse.

The second element is the creation of state level public sponsors. These agencies, like employers, would offer a choice of qualified health plans to all people who were not covered by an employer based plan. The public sponsors, like employers, would pay 80% of the average cost of the qualified health plans with which they had contracted in a given geographic area; the individual or family purchasing coverage from the Public Sponsor would pay the difference between the 80% subsidy and the cost of the health plan chosen.

Public Sponsors would offer to act as brokers for employers who wished to obtain coverage through these agencies. Small employers and even many medium-sized employers are not large enough to manage competition among health plans effectively. Moreover, small employers that buy insurance on their own are forced to pay higher rates. A public sponsor could combine these risks and achieve economies of scale. States could achieve economies in administration as well as greater bargaining power with the health plans by assigning the Public Sponsor responsibility to the agencies that already buy coverage for state employees.

Public Sponsors would also administer two additional subsidies. First, the requirement to pay, on average, 20% of the cost of a health plan will keep many low income people from being covered. The public sponsor would waive this 20% payment requirement for those below 100% of poverty, and phase it in on a sliding fee scale for those between 100% and 150% of poverty. (I should note here that we are not, at this point, proposing any changes in the Medicaid program. I'll discuss this more below.)

Second, Public Sponsors would administer a subsidy to small businesses. The employer mandate will have a greater effect on small businesses than larger ones, since small businesses are less likely to provide coverage currently. In order to cushion this impact, and minimize economic dislocation, we propose that small businesses (fewer than 25 employees) that arrange coverage through the Public Sponsor would be required to pay no more than 8% of their payroll for health benefits. That is, if the 80% contribution that is required of employers is more than 8% of payroll, small business would pay only the 8% of payroll and the Public Sponsor would pay the rest.

The third element -- the tax cap -- would limit the amount of tax free employer contribution to 80% of the average cost of a qualified health plan -- that is, the amount that employers are required to contribute. Our plan would require employers to contribute 80%, and would provide that any contributions above that amount are taxable income to the employee.

This is a key element of the plan for two reasons. First, it is a necessary ingredient to create cost-consciousness in the choice of plan for consumers. As anyone who has ever been involved in labor negotiations will tell you, the existing tax rules result in a greater allocation of total compensation to health benefits and less to cash income than would occur with a different tax treatment. The first requirement of 'managed competition' is that consumers should be faced with the cost difference among plans when choosing a provider group, and this principle is unlikely to be met as long as the entire amount of employer contribution is tax free.

The second reason why the tax cap is a key element of our plan is that it raises some of the revenues needed for the Public Sponsor to offer the 80% subsidy to individuals and families not covered by their employer. The Congressional Budget Office has estimated that the tax cap would raise approximately $11 billion if the average price of a qualified health plan was $2400 per year.

Those of us who will be paying this extra $11 billion in taxes may be unhappy about this, but there is an extremely strong equity argument to be made here. The statement typically made about Federal government health care spending is that Medicare and Medicaid are the two largest programs. But the tax expenditure for employer provided health benefits is significantly larger than the Federal share of Medicaid. And the primary beneficiaries of this expenditure are the relatively better off members of our society. Surely it makes sense to redirect a small portion of this expenditure to people with greater need.

The fourth element of our plan -- the play or pay payroll tax -- would require employers to pay an 8% tax on the first $22,500 of earnings of part time workers to whom they were not providing health benefits. For self-employed people who were not covered by the employment based policy of their spouse, this tax would be collected through the income tax system. This tax is important for two reasons. First, it would raise a portion of the revenue to support the Public Sponsor subsidies directly from people who would benefit from these subsidies. Second, it would reduce the otherwise strong incentives for employers to reduce a worker's hours from full-time to part-time status. That is, if we tell employers that they must pay 80% of the health benefits cost for full-time workers but that they need pay nothing for

part-time workers, there will be a strong incentive to create more part-time work. The tax on the wages of part-time workers will reduce this incentive.

Federal-State Cost Sharing

In our proposal the federal government would reimburse the state level Public Sponsor agencies 50% of the expected average cost of a qualified health plan for each individual/family that bought coverage from them. This is similar to Medicaid, with the major change that instead of simply paying half of whatever the state spends, the federal government would compute a national average cost, use price level adjusters to compute the 'expected' cost in each state, and pay half the 'expected' cost instead of half of the average cost. Using this sort of system the federal government will not be subsidizing the expensive practice patterns that are the norm in some states, and will reward states with relatively more economical practice patterns. As with Medicaid, this formula could certainly be changed to provide a larger subsidy to states with greater need.

States would pay the difference between the 50% federal subsidy of 'expected' cost and the 80% subsidy that the state level public sponsor would be required to offer to otherwise unsponsored individuals and families. States would be expected to finance their portion of the bill in large part from funds already being spent for uncompensated care.

Relationship to Medicare and Medicaid

We propose no initial change in Medicare and Medicaid. The public sponsors would have enough work to accomplish the objectives set out

thus far. Howeer, once this program was operating successfully, there would be opportunities to sue the capabilities of the public sponsors to assist the Medicare and Medicaid programs. For example, Mediciad programs should consider contracting with the public sponsors to provide coverage for families on welfare, in order to ease the transition from welfare to work. The existence of the public sponsor would mitigate the work disincentives associated with losing eligibility for Medicaid beacuse of an extra dollar earned, and a Medicaid-public sponsor agreement would mitigate this disincentive further. The existence of nearly universal coverage through the public sponsor should greatly reduce the number of people who 'spend down' into Medicaid.

Managed Competition, Technology Assessment, and Management of Outcomes

Public and private sponsors will have to work hard to make managed competition work. Simply requiring consumers to pay more if they choose a more expensive health plan will not automatically result in the type of market in which providers will find it in their interest to figure out how to deliver high quality, economical care.

Sponsors must continuously monitor and ajust the market to overcome its tendencies to failure. Some things they should do are relatively easy: they should monitor disenrollment from health plans and take corrective action if a health plan is 'extruding' its sickest members. They should stadardize benefit coverages, so that when consumers are comparing across plans they are making a relatively clean price comparison, and not one contaminated with benefit differences as well. They should, as most do now (although Medicare and many Medicaid agencies do not) manage enrollment themselves, and not give health plans the opportunity to discourage bad risks from enrolling.

Ohter actions that sponsors should take require more effort, but are equally important. First, they should develop risk-rated contribution systems. That is, sponsors should make larger contributions (more than 80% of average) to health plans that have a greater than average number of members with large health care needs, and should make smaller contributions to health plans with a smaller than average number of members with large health care needs. In this fashion, sponsors will reward health plans that do a good job of taking care of sick people, in contrast to the present payment system which punishes them.

Sponsors must help develop and make available to consumers information on the quality of care delivered by health plans. And sponsors must assist providers in developing programs of technology assessment, the risk-adjusted monitoring of outcomes, and outcomes management. Such information is a public good. The profit incentive does not motivate the production of such information in socially optimal amounts. Substantial support by government is both necessary and a wise investment for taxpayers in the long run.

Coverage, Costs, and Budgets

The Congressional Budget Office has estimated the effecs of our proposal on coverage costs and public-secto· budgets.

Of the 35 million people who are currently uninsured, according to CBO estimates, approximately 22 millino would be covered by their employers under the mandate, and the remaining 13 million would be eligible to purchase coverage from the public sponsors. In addition, 6

million people currently purchasing non-group coverage would be eligible to purchase from the public sponsor.

We estimate that the average cost of a minimum benefit package (similar to the one in the Kennedy/Waxman bill) would be approximately $2400 per family per year. At this premium level, the CBO estimates that our proposal would be budget neutral for the federal government. Revenues raised by the tax cap and by the tax on the wages of part-time workers and the earnings of otherwise uncovered self-employed people would offset new expenditures to support public sponsor activities (see the attached tables for details).

Effect on Employment and Wages

In a perfectly competitive market, the total payments for each worker's services -- wages, fringe benefits, and payroll taxes -- should equal the value of his or her contribution to the output of the firm. After a period of adjustment, any increase in health insurance costs or payroll taxes would be offset approximately by a decline in real wages. In real labor markets, however, various factors might prevent wages from declining by as much as the employer's increase in costs for health benefits. Thus, increases in such costs might result in higher prices or lower profits.

We expect that our proposal will cause the real wages of currently uninsured workers to decline, although for workers in small firms the size of this decline is limited to 8%. In return, these workers and their dependents will be able to obtain medical care when they need it without suffering financial hardship.

Table 1. Health Insurance Status of the American Population at Present and as Projected under the Proposal.*

Projected Types of Coverage	Totals (Projected)	Current Types of Coverage			
		Employment-based group†	Other private	Medicare, Medicaid, or CHAMPUS‡	None
		millions of people§			
Totals (current)	241.2	135.1	19.7	51.1	35.3
Employment-based group†	178.3	135.1	13.6	7.1	22.5
Medicare, Medicaid, or CHAMPUS‡	44.0	—	—	44.0	—
Public sponsor	18.9	—	6.1	—	12.8

*Source: Preliminary Congressional Budget Office simulations based on the March 1988 Current Population Survey.[29]

†Includes all people with employment-based coverage, regardless of other insurance, except those covered by Medicare.

‡CHAMPUS denotes the Civilian Health and Medical Program of the Uniformed Services. Figures include veterans covered by the Department of Veterans' Affairs.

§People are classified according to their own insurance and work status or that of the family member whose plan covers them.

Table 2. Probable Effects of Full Implementation of the Proposal on the Federal Budget.*

	Cost or Savings (Billions of 1988 Dollars)
Outlays	
Matching contributions to public sponsors	8.7
Subsidies to small businesses	3.9
Subsidies to low-income individuals and families	3.9
Cost added to health-benefit plan for federal employees	0.2
Savings to Medicare, Medicaid, and CHAMPUS†	−3.9
Total	12.8
Revenues	
Payroll tax on part-time workers‡	4.4
Income tax on others eligible to buy from public sponsors	2.5
Cap on exclusion of employer contributions from individual income-tax and payroll-tax bases	11.2
Savings from elimination of all health care benefits from Section 125 of Internal Revenue Code	§
Revenue loss from mandated employer contributions — individual income and payroll taxes	−5.7
Total	12.4
Net effect on federal budget deficit	0.3¶

*Source: Preliminary Congressional Budget Office estimates based on 1988 Current Population Survey and August 1988 base line.[29]

†CHAMPUS denotes the Civilian Health and Medical Program of the Uniformed Services.

‡Net of income-tax and payroll-tax offsets due to lower wages.

§Not yet estimated, but expected to be small.

¶Value shown is approximate because of rounding off.

Probably the most important negative effect of our proposal, as compared with the status quo, would be a reduction in opportunities for employment among people with few job skills, by, in effect, raising the minimum wage. Further provisions can be designed to attentuate this effect.

Any tax or regulatory mandate distorts economic decision making. If this proposal were enacted, there would be some negative effects on employment, as there are now in our employment-based system of coverage. But the achievement of universal health insurance inevitably entails some taxes and regulations. Our present method of providing health insurance through employment groups is subsidized by taxes to a great degree. We must look for a realistic compromise -- what economicsts call a 'second best' -- because universal health insurance without some regulation and tax support is impossible. Further, the accelerating cost of health benefits today has negative effects on real wages and employment for the majority of American workers who receive employer provided health benefits. To the extent that our proposal were sucessful in restraining the rate of cost growth, it would have beneficial effects on wages and employment for many Americans.

Will it Work?

If Congress were to enact a proposal such as ours, would it work? It would certainly get coverage to virtually all of the 35 million Americans who are currently without health insurance. In that sense, it would certainly work.

There is inevitably less certainty about the propsed system's effectiveness in restraining cost growth and in promoting the delivery

of high quality and economical care, since such forecasting such effects require forecasing the behavior of consumers, sponsors, and providers. The key to success here is creating a structure in which providers (doctors and hospitals) think that it is part of their job (and are rewarded for) providing high quality care in an economical fashion. That is not the case today, in which economical care is rarely rewarded and high quality care is inconsistently rewarded. I think that a financing structure such as the one we have proposed combined with the tools of 'managed competition' will create a system in which high quality, economical care will be rewarded and flourish, but this is not a lead pipe cinch..

I am quite sure that our proposal is far more desirable than the status quo. The status quo is that we have 35 million people uninsured, and an expensive, inflationary health care system in which there is no necessary relationship between increased spending and either better health outcomes or increased desire for spending expressed by 'society'. Surely a system in which all are insured and there is a reasonable chance for promoting economy and quality is preferrable to the status quo.

It is also important to remember that the price to get to this new system is comparatively small. We estimate that total health care expenditures would increase by approximately $15 billion (3% of current health care spending and .3% of GNP) in the first year after our proposal was enacted. As Medicare and Medicaid have taught us, the important effects of a new health care program are not seen in the static, first-year effects, but rather in the long-term effects. It is ambitious but reaonsable to set it as a goal fro our program to restrain

the rate of growth in health care spending to a rate of growth close to that of the GNP. If this favorable result were to occur, we would reduce health care costs by $15 billion per year (that is, $15 billion in the first year, $30 billion in second year, $45 billion in the third year, and so forth), as compared with the current path of expenditures. These savings, which would be shared by the government and private employers (and ultimately by wage earners), would soon dwarf the one-time cost increase that our proposal would create.

Comparison to Prominent Alternatives

The proposal from the National Leadership Commission is similar in some respects to our own, but is missing key elements that are needed to promote the delivery of economical, high quality care: namely, the tax cap in particular, and, more generally, the framework needed to make managed competition work.

The proposal from Physicians for a National Health Program differs in two important respects. First, it provides for centralized government financing rather than the current pluralistic, employer based system. There are strong arguments for a centralized financing system, and 'managed competition' with centralized financing was proposed by Alain Enthoven ten years ago in 'A Consumer Choice Health Plan for the 1980s'. But centralized financing would require a tax increase of at least 200 billion dollars. It seems unlikely that we will see this anytime soon, and in the meantime we will continue to have 35 million uninsured and accelerating cost growth.

But if the current health care crisis deepens to the point where centralized financing becomes a political possibility (as it might in a

steep recession), then it is important to consider how the money should be allocated. There are many attractions to a system, such as Canada's, in which hospitals receive global budgets and physicians' clinical judgment is not questioned by managers or bureaucrats. Such a system can probably be operated with lower administrative costs than a system based on managed competition.

But the cost of this administrative simplicity is little confidence that doctors and hospitals will see it as an important part of their job to figure out how to provide high quality economical care. It is true that the combination of professional norms to improve people's health with resource constraints will push in the direction of figuring out how to use a fixed budget wisely. But we should also expect that provider driven allocations of health care dollars will be strongly influenced by internal politics within the professions and the hospital industry. There is little in such a system to promote the systematic examination of what works and what does not, and to promote the adoption of technologies and treatments that work and to avoid adoption of technologies and treatments that do not.

Mr. WAXMAN. Thank you very much. Let me start with you, Mr. Kronick. Is your cost containment strategy for health care based on the notion that there would be some shopping around between plans, or is there some other mechanism that will hold down costs?

Mr. KRONICK. The two main components of it are one, a system of managed competition in which—I think you "shorthand" called shopping around. It is, in fact, much more than that. Clearly, the individual consumers are pretty powerless to shop around and figure out which health plan is providing good quality care.

The role of the sponsors is key there. Whether employer sponsors or public sponsors—and here we see the public sponsors as kind of the cutting edge as good examples for private employers, need to do much more than simply sign a contract with health plan and make the choices available. They need to monitor enrollment, they need to monitor disenrollment, they need to make sure that if there are some health plans that have more sick people they get paid more. The health plans which manage to skim healthy people aren't in the business.

So, individual consumers need a lot of help. Yes, at least there is a notion that with a lot of help individual consumers can choose among health plans and that would create an environment in which providers would be rewarded for figuring out how to do it better.

Mr. WAXMAN. Do we have any model that we can look at to see such a public agency sponsor that operates in this way? It is an advocate, it is taking on enormous responsibilities of power.

Mr. KRONICK. I think that it may not be an opportune time to bring it up because they know it has problems, but the Federal employees health benefits plan is a sponsor. It is a sponsor for employed people.

That is the kind of model, the State of Massachusetts, a group insurance commission in California, the PERS, that kind of agency is a model for at least part of the business.

There is another part of business in terms of enrolling people that would clearly be different for the public sponsor than for OPM here. It is similar generically, but different because you don't have an employee population.

Mr. WAXMAN. Mr. Schramm, I don't know if you have had a chance to look at this proposal, but do you have any reaction how this might work if you had this kind of agency handling, I guess intervening actively in the various insurance plans?

Mr. SCHRAMM. I think to the extent that the problem is uninformed consumers and, perhaps small employers who would be uninformed would essentially have to pool their expertise and knowledge in terms of making purchases. The plan has a lot to recommend.

I am not sure that's the fundamental problem.

Mr. WAXMAN. What is the fundamental problem?

Mr. SCHRAMM. The fundamental problem is there are multiple cuts at this, as you know. It is not clear to me that the most fundamental of the problems, namely cost inflation, the number of uninsured we have in the United States today is probably 10 million larger than it was a decade ago. I think virtually all of that can be laid at the doorstep of inflation and the underlying provider costs.

It is not clear to me that this plan goes to it. It relies again on tons of market signals and incentives. We have been through a decade of that type of experience. At the back end of the decade one could hardly say that we are better off.

Mr. WAXMAN. Let me ask Mr. Tallon, if we went with the approach that you are suggesting, what kind of mechanism would we have to hold down health care costs?

Mr. TALLON. Mr. Chairman, the report indicates the need to adopt cost-effective strategies. It is clear that we did not go in length in the report into trying to adopt new approaches. I would offer you this observation from my experience.

I believe that one of our weaknesses in trying to adopt cost-effective strategies is this lack of universality of a coverage system, combined public/private system, a public system or whatever. The difficulty is that we are constantly at cross-purposes.

As we try either through the use of the market or in my own State where, if I were wearing the hat of my State, I would be discussing the regulatory initiatives for which we have become famous. As we take those steps, we are constantly at the cross-purpose of trying to fill the holes in coverage for people who are without coverage.

So I would say to you as a beginning, I am not sure that there are new ideas out there. Either we are going to come in from the top with a regulatory strategy, we are going to try to manage care and have some degree of savings off the case-by-case management of care. Some would argue to open up markets to greater amounts of information.

The strategies have been discussed. It just strikes me that one of the weaknesses we have in following through on the implementation of any strategy is this lack of sub-universality of coverage because that constantly keeps us at cross-purposes with ourselves.

Mr. WAXMAN. Let me call on Mr. Nielson. We will get back with some of these others.

Mr. NIELSON. Mr. Tallon, let me ask you a question. Your proposal calls for a total restructuring of the Medicaid based on uniform Federal regulations as I read this and understand it.

Mr. TALLON. It's a substantial restructuring sir, yes.

Mr. NIELSON. Does this move to Federal control, the limit and what the States can do? Does it interfere with the individual State's ability to administer their own Medicaid programs?

Mr. TALLON. It does not talk about taking State administration away, sir. It certainly moves in the direction both by standardizing eligibility at the Federal poverty level and by adopting a standard benefits package to restrict the variation that States currently have.

Quite frankly, that dilemma of State-by-State variation is right at the core of the problem with why Medicaid fails to meet the coverage needs of 11 million uninsured poor people. It does move in that direction. It does, however, contemplate a continued State and Federal role.

In the cost discussions we asked Professor Thorpe to do a detailed cost analysis. We did not try to cut the cost analysis short. We think that it is realistic, even if it places numbers before us which are difficult to face.

Mr. NIELSON. You indicate the revisions of the cost would cost between $13 and $28 billion beyond present Medicaid expenditures.

Mr. TALLON. Mr. Nielson, may I simply announce here that I think almost any one of these plans, as we start to talk about them, is going to cost roughly that same amount of money. I think we went in some detail in admitting it.

Mr. NIELSON. I am not criticizing your numbers. I am saying how should the Federal government carry this additional burden? You have had to balance budgets in New York and so forth, how would you do it?

Mr. TALLON. I think that you are going to have to come within either an existing revenue as they grow or you are going to have to come with a new revenue source. I don't know how else to do it.

There are revenue sources that have been discussed. One of them mentioned that earlier in their testimony. We did not try to identify that for you. We also did not try to duck the question that there are additional costs associated

I would also point out sir, that exactly how much this costs is sensitive to the question of what strategies you adopt for people adjacent to the poor. Of that 13 billion minimum figure, you would cut that number roughly in half were the employer mandate on the table.

Mr. NIELSON. Your heard Mr. Richardson say this morning that he had a lot of comments on that catastrophic health care. I have had about 50 town meetings this time, and I hear that all the time. Their problem is not so much that they resent the $4 extra cost on the part b, it's the surtax they are looking for next year that they are concerned about.

They are also resentful of the fact that they negotiated health care when they were in their working years with their employer, sometimes giving up salary in order to get health benefits. They resent the fact that they had made some preparations to take care of their health care. Others did not and yet, on the catastrophic health care everybody starts from zero.

They feel as though it is an unfair windfall to the companies that they worked for, number one. Number two, it is unfair wasting of their resources. What would you say about that?

Mr. TALLON. Mr. Nielson, the group of people who we tried to focus on are people who indeed do start from zero, or start from very little access to care. What we simply put before all of us is that there is probably an unavoidable governmental responsibility for this group, whether it's that 11 million people, 6 million people.

As we discuss this topic, we simply have to include this group. I think that there is an unavoidable problem here, and it does present expenditure questions at the Federal level and it will present those expenditure questions at the State level.

My concern is with discussions on this general topic of 37 million uninsured that don't fully recognize the poor as a central problem, perhaps with the greatest health need, that there does have to be public expenditure and we have to face that in the solving of the overall problem.

Mr. NIELSON. Mr. Kronick, you mentioned that the employer pays 80 percent of the cost and the employee pays 20 percent. If it is not available for them from the particular employer he can then

go to the State or Federal government and pick a group of plans. The Federal government then would pick up 80 percent and he 20 percent; is that correct?

Mr. KRONICK. No, sir. The employer would be required to pay 80 percent for fulltime employees.

Mr. NIELSON. But what about the company which is too small to have such?

Mr. KRONICK. The public sponsor we would see as a broker agency, so that any company whether small or large—but we would expect mostly small companies—could go to the public sponsor and say I want you to arrange for health benefits for my employees.

Small companies, and this is actually a big expenditure item, we propose a subsidy so that small business, fewer than 25 employees, would have to pay no more than 8 percent of their payroll if the 80 percent was more than——

Mr. NIELSON. My question is, is there some way for a company, small or not, to avoid providing this insurance, if there were and then go to the Federal or State government and get the same thing; would there not be an incentive for the companies to avoid the responsibility?

Mr. KRONICK. You have hit it on the head.

Mr. NIELSON. Would you not have fewer people offering it than you have now?

Mr. KRONICK. You have hit it on the head. I think that one of the difficulties as people think about Medicaid expansions is that if you have a government program that provides benefits to people who are working, you have a big problem of leakage out of the private sector into the public sector.

Our proposal would require companies to provide benefits, and so that leakage problem wouldn't be there.

Mr. NIELSON. I thank you. I have other questions if we have another round.

Mr. WAXMAN. We will come around. Thank you, Mr. Nielson. Dr. Rowland.

Mr. ROWLAND. Thank you, Mr. Chairman. Dr. Taylor, you were in clinical practice?

Mr. TAYLOR. No, sir. I have been a salaried physician all my life by choice. I have never been in private practice.

Mr. ROWLAND. Clinical practice I said.

Mr. TAYLOR. Clinical practice, yes, sir.

Mr. ROWLAND. What type of practice?

Mr. TAYLOR. Internal medicine.

Mr. ROWLAND. You were in practice in the 1950's then?

Mr. TAYLOR. Yes, before and after.

Mr. ROWLAND. What about the health care delivery back in the 1950's.

Mr. TAYLOR. My experience in North Carolina have been, because that is where I lived and was working, I would think that the major problem we faced in that State in the 1950's was the actual number of physicians in practice in the State.

We looked at our position at the Medical School in Chapel Hill to expand the educational opportunities to North Carolinians who would go into practice in North Carolina and we succeeded in

doing that, we and every other medical school I guess. Now they talk about a surplus of physicians. I could hardly believe it.

I went to the General Assembly of North Carolina in 1964 and I said, never in my lifetime if we work as hard as we can, will we ever have enough doctors. I was dead wrong.

Mr. ROWLAND. What would you say about the quality of care back in the 1950's?

Mr. TAYLOR. I think the quality of care for those who had access to it was excellent.

Mr. ROWLAND. What about access to it?

Mr. TAYLOR. Access was fine if you had an automobile. For the predominantly rural population of North Carolina at that time, without much money and with very few overworked doctors in the county seat, it was very hard for them to get any medical care.

Mr. ROWLAND. What about the cost of care?

Mr. TAYLOR. The cost of care was certainly affordable by those who could——

Mr. ROWLAND. Transportation was the main problem then where you were?

Mr. TAYLOR. Transportation and availability of physicians, both were.

Mr. ROWLAND. I guess you didn't hear these two ladies this morning talk about how they couldn't get care.

Mr. TAYLOR. Yes, sir, I did.

Mr. ROWLAND. You think they could have gotten care back then?

Mr. TAYLOR. If they had come to Chapel Hill they could have. In the State operated hospital subsidized by the legislature with North Carolina tax dollars, those ladies could have been adequately cared for. I don't know if that would have been possible in many other centers in North Carolina. In Mecklenburg County and surrounding counties where Charlotte is located, that would have been possible.

Around Durham where Duke University is, around Winston-Salem. The resources at the time in North Carolina to the treatment is kind of complicated problem that the second lady talked about.

Mr. ROWLAND. What about local communities putting money into hospitals then and providing care for people?

Mr. TAYLOR. The local communities were generous to the limits of their resources, I would say. The pushed themselves to do it.

Mr. ROWLAND. Do you think we have problems that are much worse now than we had back then in health care?

Mr. TAYLOR. I think we have problems certainly with the expectation of the American public, and with what medicine could offer. I think medicine now has the possibility of prolonging life and treating disease and correcting surgically, for example, vascular disorders which I didn't dream of in the 1950's and which have been developed largely I must say through—I hasten to say through the very successful Federal program represented by the National Institutes of Health in support of biomedical research in this country.

To the point where now we are—unless people can have the resources and can pay for the resources of what we used to call ter-

tiated medical centers, people are deprived and their expectations certainly are not met.

I think the difference in the—I recently saw a study about the difference between whites and blacks in the availability of cardiac cauterization and coronary bypass surgery, and blacks were far below whites.

Mr. ROWLAND. Thank you.

Mr. WAXMAN. Thank you, Dr. Rowland. I would be interested in the point that you are making Dr. Taylor, and I think it's the point that everyone here agrees on is that it is not right to have people uncovered. Their expectations from what people can get from medical care which are higher than they were a couple of decades ago based on very good facts, and that is medicine can be helpful to people and because of that help people shouldn't be denied that coverage.

You would put the whole system, in a unitary way. You wouldn't have this pluralistic system of private insurance or public insurance, is that correct?

Mr. TAYLOR. What we propose would be a unitary financing mechanism for health services. We think that the multiple insurance coverages which are now available and the multiple government programs which are available are extremely expensive and confusing, and time-requiring for doctors, and a burden upon hospitals and other health providers.

The Canadian experience has certainly been that they can operate the system of fiscal reimbursement of providers with much less overhead than we are presently doing in the United States.

Mr. WAXMAN. Let me ask Mr. Schramm, how do you respond to that? If this pluralistic system simply is costing a lot more money and not getting more care to people, in other words wasting the system, why don't we go to a unitary system?

Mr. SCHRAMM. Mr. Waxman, I would make two comments to that. The first is, the fundamental premise of Dr. Taylor's plan really rests on the waste involved in administration. I don't know what that is. I am not sure if there are good estimates. It is undoubtedly correct that the cost of administering the American system is several multiples more than the cost of administering the Canadian system.

That largely exists as our pieced together mechanism for regulating the delivery system. That is just a fact of life. It is invented by State Medicaid agencies, it's invented by HFCA, it's invented by private insurance companies, and we are in the spade of inventing it in spades at the current time as we really develop managed care systems the future in which all of our companies have staked their future and Medicare stakes its future.

The second point really relates to a political call. I just can't conceive of us about to abandon everything that we have built to go in the direction of the Canadian system no matter how desirable it is. That is really a political call.

I largely look at history in Canada where the program began in 1947 and then moved to all provinces by 1971 as a time when the same movement might have happened in the United States.

Mr. WAXMAN. Your judgment is that politically we should not move there. Dr. Taylor.

Mr. TAYLOR. Our expectation of cost control go far beyond retrieving administrative costs. We feel that a unitary source of funding will give an opportunity for the control of expenditures. In my view, I am a congenital Democrat and believe in government, when we have 12 percent of the gross national product spent each year on what I would consider to be an essential service, I think there ought to be some kind of legislative review of that expenditure.

That certainly is not the case now. Medicare is trying to do something about it, and the result has been chaotic. DRG, nobody is happy with what Medicare is trying to do in the control of Medicare costs.

Mr. WAXMAN. I would like to hear Mr. Kronick respond to this discussion.

Mr. KRONICK. I think that there are two major departures in Dr. Taylor's proposal from what various other people have talked about. One is centralized financing and the other is how that money gets allocated.

On the centralized financing issue, I think there would be a lot of advantages to it. There are certainly dangers, as Professor Reinhardt discussed earlier about turning the spigot too tightly or allocating the money incorrectly. There are lots of dangers, but there would be many advantages to centralized financing.

Certainly Professor Entoven, 10 years ago when he proposed a consumer choice health plan for the 1980's which didn't get adopted, proposed a system which had centralized financing in it.

I think the second question is if you and your colleagues were to raise the $300 billion or so in taxes that would be needed to accomplish centralized financing, if the crisis were to get back enough so that a $300 billion tax increase was politically feasible, then how do you get the money from the government to the providers?

There are a lot of advantages in the Canadian model. There are also some disadvantages. Basically, if you give money to the providers and say you figure out how to allocate it among yourselves, there would be a political allocation within the provider community.

I think there's a question about the extent to interaction provider norms to do good with resource constraints will get you a good outcome versus all of the internal politics within hospitals and within professional associations that may have that money not used any more efficiently or much more efficiently than our current system.

Mr. WAXMAN. Mr. Nielson.

Mr. NIELSON. I have heard estimates from Mr. Tallon about $13 billion and $28 billion. You just gave us a $300 billion figure. Let me ask the question and Dr. Taylor might want to respond to your $300 billion which appears high to me.

The Chairman leaned over to me and said don't go after Dr. Taylor because he's a Democrat. I told the Chairman that my mother and my wife are both Democrats and I am accustomed to dealing with Democrats. My wife has since converted, of course.

Anyway, are you merely transferring the dollars you talk about from the government to the extra cost to the employer and employee?

Mr. KRONICK. Our current health expenditures are $550 or $600 billion, depending on what year that you are talking about. The government spends about $200 billion. If you were going to have a system in which the government was basically spending most of health care, I am saying $300 billion if it was all like before.

Mr. NIELSON. In your plan, your's is going to have higher employee costs and higher employer costs.

Mr. KRONICK. In our plan, total government expenditures would increase by about $12 billion. That would be offset by $12 billion of new revenue. In addition to that, there would be additional employer expenditure.

Mr. NIELSON. I am having difficulty understanding how you can do it for $12 billion and his is going to cost $300 billion. That doesn't seem to make sense to me.

Mr. KRONICK. In our plan, employers would still provide health care to the majority of Americans or at least of working aged Americans and their dependents.

Mr. NIELSON. Won't there be some business—some companies go out of business on this cost? Won't there be some cost that way?

Mr. KRONICK. There may.

Mr. NIELSON. Lost jobs and things of that nature?

Mr. KRONICK. There may, but there are also business' that will go out of business now because health care costs are increasing so quickly. Most people when they get really sick eventually get care and somebody pays for it.

Mr. NIELSON. I would like Dr. Taylor to respond to that. He is charging you many times what is willing to cost his out. I am not sure which is the best CPA between you.

Would you comment? It seems to me like you are being painted as a very great big spender. My daughter lives in North Carolina and I don't think anyone down there has that reputation in either party.

Mr. TAYLOR. Well, sir, what we would propose, for example, what industry now spends for health benefits for its employees would go to the central health care funding pool. What Medicare spends and what the States and Federal government paid for Medicaid all would go into this central pool.

I certainly am not an accountant or even an economist, and I really don't know the details of this. It seems to me very likely that a great part of this $300 million could be made up out of present expenditures refocused into a common funding source.

Mr. NIELSON. The difference between your two problems is more a way of accounting for it rather than the actual cost of the program?

Mr. TAYLOR. That's correct, sir.

Mr. NIELSON. You both concur with that.

Mr. TAYLOR. Yes, sir.

Mr. NIELSON. Mr. Schramm, what would be the cost of your proposal, your increase in Medicaid? I am just trying to get some numbers. You talked about having choices of programs, and I would like to get some costs.

Mr. SCHRAMM. The public part of our program is Medicaid. The numbers wouldn't defer very much from those Ken Thorpe gave with respect to the poor. Most estimates for covering that popula-

tion vary between $7 and $14 billion. The basic difference is the different assumptions you make about participation rates.

However, ours would save some money because we say that government should go ahead and take advantage of private coverage where it exists. You can take that maximum outside figure of $13 billion and, in our judgment, reduce it by about $4 billion.

Mr. NIELSON. Do you believe——

Mr. SCHRAMM. Can I make one other point. We have also designed a Medicaid buy-in program for the near poor. Our estimate of cost of that is $1 billion total Federal and State, which is a small fraction of other proposals.

Mr. NIELSON. If commercial insurers were able to offer their own health care plans without being required to meet certain State or Federal standards, could they save money to the insured?

Mr. SCHRAMM. Positively.

Mr. NIELSON. If they could save such money and could offer more affordable programs, what would happen if they still refused to do it in that case? What would you do with a company which refused to provide such insurance even though it became more affordable?

Mr. SCHRAMM. A company that refused to buy insurance?

Mr. NIELSON. Yes. If a small business was not going to make it available to its employees under your system, what would happen to such employees under your system?

What enforcement mechanism do you have to make sure that small business' do offer it, for example? Mr. Kronick said that they can't escape it. In your situation, could they escape their responsibilities?

Mr. SCHRAMM. Well, I'm not sure we provided for that.

Mr. NIELSON. That is a wrinkle that we need to work out; is that right?

Mr. SCHRAMM. That's right. The presumption is that historically most employers have seen this as a duty. There is a tax incentive to do it, and most employers have, in fact, provided for health insurance.

Mr. NIELSON. Thank you.

Mr. WAXMAN. Thank you, Mr. Nielson. Did you just want to respond to that point?

Mr. TAYLOR. I would like, if I might, Mr. Chairman, to make a remark about who pays for health services now. We talk about employers paying for. Sometimes we talk of it as if that were not costing the general public anything. That, obviously, is not the case.

When General Motors pays $5,000 per year per employee for health insurance, then all of us who ride in taxicabs or public buses or own automobiles pay that. As someone said this morning, if we are paying $600 billion a year for health services, we can certainly cut that cost and have a first rate health program.

Mr. WAXMAN. Dr. Rowland.

Mr. ROWLAND. Thank you, Mr. Chairman. I want to go back to what we were talking about a few minutes ago, Dr. Taylor. I think that you said that the principal problem that we had back in the 1950's was lack of doctors and lack of transportation. These ladies that testified this morning could probably have gotten their health needs met if they had that available to them.

I believe you also said that back then the States were furnishing some of the cost of care, and local communities were also furnishing some of the cost of care.

Mr. TAYLOR. That is certainly true in North Carolina.

Mr. ROWLAND. In fact, the Federal government was furnishing a lot less of the cost of care at that time.

Mr. TAYLOR. Yes, sir, that's correct. As I understand it, Medicare and Medicaid were the first real.

Mr. ROWLAND. In 1965.

Mr. TAYLOR. In 1965.

Mr. ROWLAND. I am curious to know why you think that we need to go to a unitary system. That system seemed to be working pretty good insofar as furnishing funds for cost of care at that time. The private insurance industry was also involved.

Why do you think that it would be better to go to a unitary system when we had a system that seemed to be furnishing the care pretty well back then? I recall that I did my training, residency programs in a city/county hospital where they picked up most of the cost of the care then. I didn't hear all the problems that we have now.

What makes you think that we would be better off by having the Federal government fund all of the care?

Mr. TAYLOR. I didn't mean to imply that I think things were ideal in the 1950's. In fact, I really do think as I consider it a little more, I think that our problems were worse then than they are now. Problems for the aged certainly were before Medicare came in. Problems for the poor were worse than before Medicaid programs were widely adopted.

I think I misspoke if I gave the impression that the situation was acceptable in the 1950's.

Mr. ROWLAND. Do you think access to care was even more difficult then than it is now?

Mr. TAYLOR. Yes, sir. I certainly do think it was. Certainly, for groups which have been the subject of Federal programs for their support.

Mr. ROWLAND. Did we hear a lot from people about access to care then?

Mr. TAYLOR. Now?

Mr. ROWLAND. No, then. Did we hear a lot from people about access to care then?

Mr. TAYLOR. No. In my view, that is a silent population. You hear plenty in North Carolina if the editor of the country newspaper can't get to a doctor. When his cooks illegitimate daughter can't, you never hear about that.

Mr. ROWLAND. I just wonder if there's a different phenomenon now than there was then, because we hear so much about access to care now that we did not hear about problems with access.

Mr. TAYLOR. We hear a great deal more about it this year than we did last or 5 years ago. I think in parts it is because people's whose voices can be heard like General Motors or like U.S. Steel or like Chrysler, are beginning to realize what the real costs are going to be.

Mr. ROWLAND. Why are the costs going up so much like that? May I suggest that one of the reasons the cost is going up to Gener-

al Motors is because we have a Medicare program that is not meeting its responsibilities and that responsibility is being shifted to the private sector and those health insurance costs are going up for that reason, and that's the reason why we are hearing more from these people?

Mr. TAYLOR. I certainly think that we have a government which isn't meeting its responsibilities, not only in Medicare but in many other ways too. There is an attempt to shift this to the private sector. But as I say, if it is shifted to the private sector we are going to pay for it just as surely as if it were a part of the income tax.

Mr. ROWLAND. Certainly we are. We are paying for it.

Mr. TAYLOR. Yes, sir.

Mr. ROWLAND. The private sector is paying for it.

Mr. TAYLOR. That's right.

Mr. WAXMAN. Would the gentleman yield to me?

Mr. ROWLAND. I will yield.

Mr. WAXMAN. I am just trying to figure out historically what happened in the 1950's. As I recall the debate, although I wasn't following it real closely at the time, people who retired couldn't get insurance even if they could afford to pay for it in many cases. And, a lot of them couldn't afford to pay for it, and that's why we had the demand for Medicare.

Of course, that was the middle class seniors who are a focal group. Now the poor have gone without care then and they go without care now, and I sort of think they go without care and nobody quite knows about it or realizes it.

Mr. TAYLOR. That's right.

Mr. WAXMAN. I think we are hearing from a lot of businesses in this country today because they see the consequences of not insuring poor people. We probably hear more from them about poor people than we really hear from poor people.

My view of poor people is that they suffer, but for the most part, the rest of us don't know the extent of their suffering.

Thank you for yielding.

Mr. ROWLAND. My time is up.

Mr. WAXMAN. Without objection, the gentleman's time will be extended. I have no further questions.

Mr. ROWLAND. I guess the thing that I am really concerned about is going to a unitary type system when we say that the Federal government is going to fund all of the care. I have always felt like that if you didn't put something into a particular situation, you wouldn't really appreciate it as much.

So I have the feeling that if we go to a system where the Federal government is funding everything—of course, it comes from the people anyway—but if we go to that kind of system and there's not being much put in from State or local governments from the people themselves directly, how much will they appreciate that?

I am really concerned about that aspect of what you are proposing.

Mr. TAYLOR. I wouldn't question for a minute, the appropriateness for your concern about that. I am not a political scientist nor an economist. That kind of details about balance and so forth of

sources is something which has to be worked out in the political forum.

Yet, I feel very strongly that government needs to be able to control the level of expenditures for health services. It is an essential service, just like the fire department or the police department is an essential service. It is a huge service, now almost 12 percent of the Gross National Product.

I think our democracy requires that the agency managing our social problems have a chance to control and have a say in expenditures for health care in relationship to other national priorities.

Mr. ROWLAND. It is essential. It is essential to the way of being of our country. I certainly agree with that.

Mr. TAYLOR. Yes, sir.

Mr. ROWLAND. Mr. Chairman, if I may just say one more thing before you leave me. There were some things that weren't addressed here that you mentioned in your paper here. What about biomedical ethical issues that you don't even talk about here; keeping people on life support systems.

How are you going to deal with that? How are you going to make a determination about who is going to get what? Obviously, everybody who needs a heart transplant can't get a heart transplant. There are a lot of issues like that that I don't believe are dealt with in the proposals that you have here.

Abortion is another whole area that is going to be a great concern to pro-life people particularly. Those kinds of issues, I don't believe are dealt with here. I am not asking you for an answer right now, because my time is out. I just wanted to make some comments.

Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you, Dr. Rowland. I want to thank each of the members of the panel. You have been very, very helpful. I think that we have learned a lot from your presentation to us, and we are going to learn more as we try to digest some of your suggestions to us. Thank you very much.

That concludes the business before the subcommittee. We stand adjourned.

[Whereupon, at 2:41 p.m., the subcommittee adjourned.]

○

98-680 (144)